NHS

Kent Community Health

NHS Foundation Trust

"the most challenging year in NHS history..."

Welcome to our 10th annual report

2020 to 2021

we care

www.kentcht.nhs.uk

Kent Community Health
NHS Foundation Trust

Annual report and accounts 2020 to 2021

Presented to Parliament pursuant to Schedule 7,
paragraph 25 (4) (a) of the National Health Service Act 2006

@2021 Kent Community Health NHS Foundation Trust

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Snapshot 2020 to 2021

These numbers don't tell the whole story about the incredible work of our staff – it's a small snapshot of the past year.

3,317,900
pairs of gloves

2,628,480
disposable aprons

"We are all working hard together to beat this virus and I am proud to work for the NHS."

54,960
visors

66,048
FFP3 masks

67,053
tubs of chlorine wipes

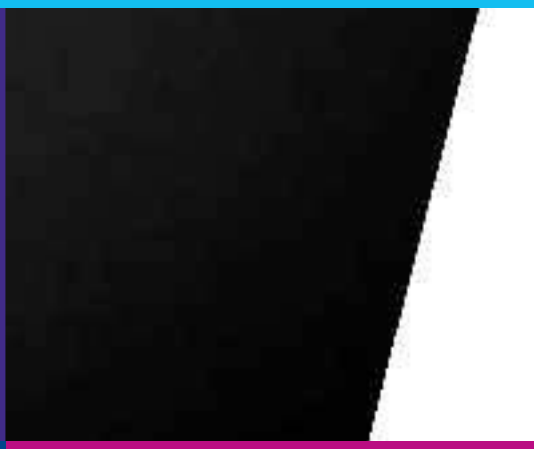
"I feel like I'm making a difference and I know the hard work of the Personal Protective Equipment (PPE) Team is appreciated."

2,627,900
surgical masks

"It is a difficult time for patients but we're helping by doing little things that matter, such as making sure their phones are charged."

"Patients on the ward couldn't have visitors, so to lift their spirits I was singing into my mop."

6,900
goggles



"The pandemic has shown the NHS at its best – people from all jobs, all walks of life, pulling together."

649.91
litres of alcohol gel

UK lockdown began on 23 March 2020.

In all, **470** staff were redeployed in wave one to help colleagues in tier one services, followed by 120 whole time equivalent in wave two.

We **launched digital consultations** for our service, where appropriate, and carried out thousands of online appointments.

At the height of the pandemic in May 2020, we had 73 Covid-positive patients in our community hospitals – on 23 March 2021, we had two.

Our Facebook following increased to more than **12,500** as people looked to us to provide the latest information and advice.

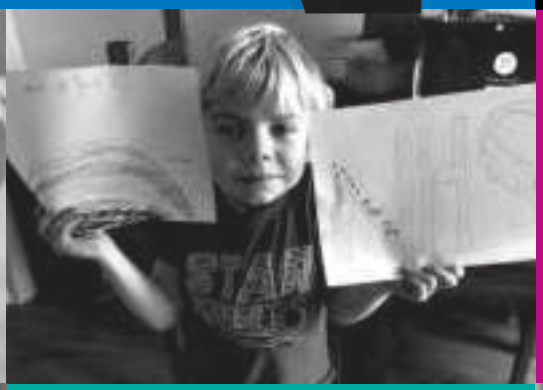
Our Estates Team completed 323 risk assessments to make sure everyone remained safe as services returned to our buildings.

We had excellent staff survey results. Out of 10 themes, we had the top score in five of them: Quality, diversity and inclusion, health and wellbeing, immediate managers, morale and safety culture.

To keep colleagues up-to-date, we sent **186 digital newsletters** – with a daily briefing at the height of the pandemic and launched a dedicated Coronavirus hub on our intranet to give colleagues easy to digest latest information and guidance.

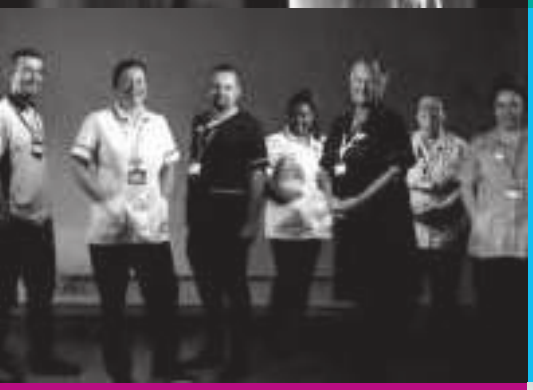
At the start of the pandemic, the trust received more than **150 enquiries to volunteer** – 25 new volunteers helped in our community hospitals and made deliveries to patients.

In the past year, we treated **655 Covid-positive patients** in our community hospitals.



Our charity i care received a staggering **£27,585 of generous donations** on our Just Giving page and NHS Charities Together donated £120k to help our staff through the pandemic.

When visiting was suspended, we helped keep loved ones connected by buying **45 tablets**, shared across our community hospitals in Kent, so patients could video call their families and stay in touch.



We delivered **2,472** training sessions, **20** virtual career workshops for staff and welcomed **315** apprentices.

We recruited 3,800 external and 1,400 internal team members to support our vaccination programme.

Overview of performance:
Welcome to our 10th annual report

This annual report 2020/21 covers the year in which COVID-19 took over our lives and changed so much in the way we provide healthcare and the way in which the NHS is perceived by the people we serve. The impact of the pandemic has changed the country and has impacted so many in such profound ways and while we take a moment to reflect upon the work of the trust, we want to recognise the loss and suffering which so many have experienced this year.

We are very proud of our 5,117-strong workforce – increased by the teams delivering the vaccination programme – who continue to deliver high-quality care to the people we serve in Kent, Medway, East Sussex and parts of London. That pride in our work and the amazing people we have at KCHFT has helped us address the challenges bought about by COVID-19.

The Covid crisis has provided excellent examples of colleagues stepping up every day to deliver incredible care and this report seeks to celebrate those staff because, as always, during the past 12 months, our focus – despite the pandemic – has remained the people we see, treat and care for together with their families, our people and our partners as we continue with our mission to empower adults and children to live well, to be the best employer and work with our partners as one.

In the period covered by this report, our achievements as a trust have been remarkable.

Our outstanding teams have developed new ways of working and embraced technology like never before to make sure the most vulnerable in the community could still be cared for, despite the restrictions placed on us by COVID-19.

The contribution of each and every KCHFT team member – whether in a frontline or supporting role – is commendable.

In March 2021, the results from the last national staff survey, which took place in the autumn, were announced. And what fantastic feedback it was. The questions are grouped into 10 themes and in the majority of these, we scored significantly higher than the other community trusts we were benchmarked against. In five of them, we had the top score. These were: Quality, diversity and inclusion, health and wellbeing, immediate managers, morale and safety culture.

The Freedom to Speak Up index is calculated as the mean average of responses to the following four questions from the 2020 NHS Staff Survey:

- per cent of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- per cent of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)
- per cent of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)
- per cent of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 17b).

The national average of the index was 79.2 per cent and community trusts averaging 84.6 per cent in 2020. KCHFT scored 87.0 per cent the second highest ranking trust in the country compared to the best of 87.6 per cent.

Our vision is to be the best employer for our people and these results will help us strive to be even better at supporting and empowering our staff during one of the most challenging years in NHS history, and in years to come.

And while our priority is the delivery of great care for all the people we serve, managing the money well means we can provide outstanding care and invest in what our patients, clients and service users need. We also remain in a strong, stable financial position, with the highest rating for our financial performance.

The pandemic is far from over, we know that, and while the delivery of the Kent and Medway vaccination programme is another great success story in how we have worked together to protect our population. We know the effects of the pandemic are long-lasting.

The challenges remain and that is why we want to thank all our team members for the exceptional work they have carried out this year for the people we see, treat and care for. We thank you for your support during these 12 months, we really appreciate it.

John Goulston
Chair

Signed

Date: 17 June 2021

Paul Bentley
Chief Executive

Signed

Date: 17 June 2021

Who we are and what we do

Kent Community Health NHS Foundation Trust was formed in April 2011. We are a large provider of NHS care in patients' homes and in the community in England. In July 2019, the trust was rated as outstanding by the Care Quality Commission.

Our budget was £248m but we spent £257m including £11m on the Covid response (of which £3m related to the vaccination programme). Our year end accounts show expenditure of £269m because it includes expenditure for PPE we received free (but paid for and valued nationally) and for employers pension costs which were paid by NHS England. We employ in the region of 5,117 (31 March 2020) in a wide range of clinical and support roles. We serve three million people; 1.5million living in Kent and 1.5million people outside of Kent.

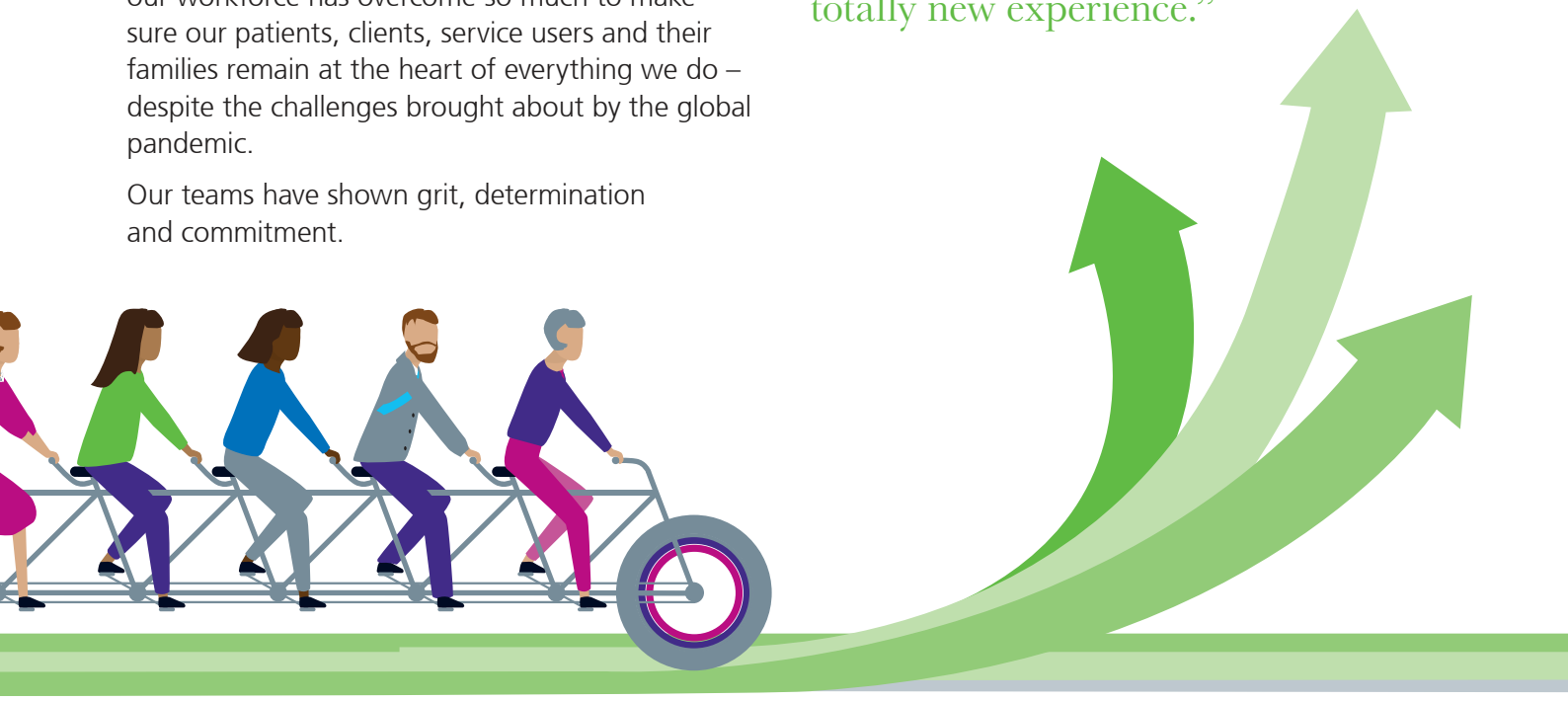
Our workforce includes doctors, community nurses, dieticians, health visitors, dentists, podiatrists, occupational therapists, physiotherapists, family therapists, clinical psychologists, speech and language therapists, radiographers, pharmacists, health trainers and many more.

In March 2020, COVID-19 was something we knew little about. During the past 12 months, our workforce has overcome so much to make sure our patients, clients, service users and their families remain at the heart of everything we do – despite the challenges brought about by the global pandemic.

Our teams have shown grit, determination and commitment.

In April 2020, hundreds of staff were temporarily moved into new roles to support colleagues delivering essential services. These included those who picked up mops and buckets to help with hospital cleaning, community dietitians who moved into hospitals to help patients in intensive care, children's nurses who worked with adult patients and an information analyst who joined a hospital catering team. Others found themselves supporting patients at the worst time in their lives, providing the very best care they could.

When Julie Caddock, Clinical Services Manager in East Sussex, heard Edenbridge and District War Memorial Hospital's cleaning team needed extra help, she put her hand up straight away. She said: "I volunteered because I wanted to help out and welcomed the opportunity for a totally new experience."



Our clinicians embraced change like never before as the pandemic meant they had to create new and innovative approaches to delivering care, including more virtual – by video or phone – appointments.

Our East Kent Frailty Home Treatment Service is good example of a service changing the way it worked to meet the complex needs of patients in our community during the pandemic. The service supports people with frailty and complex conditions to stay at home rather than be admitted to hospital.

Consultant Geriatrician Shelagh O'Riordan said: "We quickly realised at the start of the pandemic we needed to keep as many people away from main (acute) hospitals as possible, and thanks to some fast planning and a flexible workforce, we were able to do exactly that."

Our School Health Team offered children, young people and their families access to help and counselling on the phone and our health visitors were also just a phone call away.

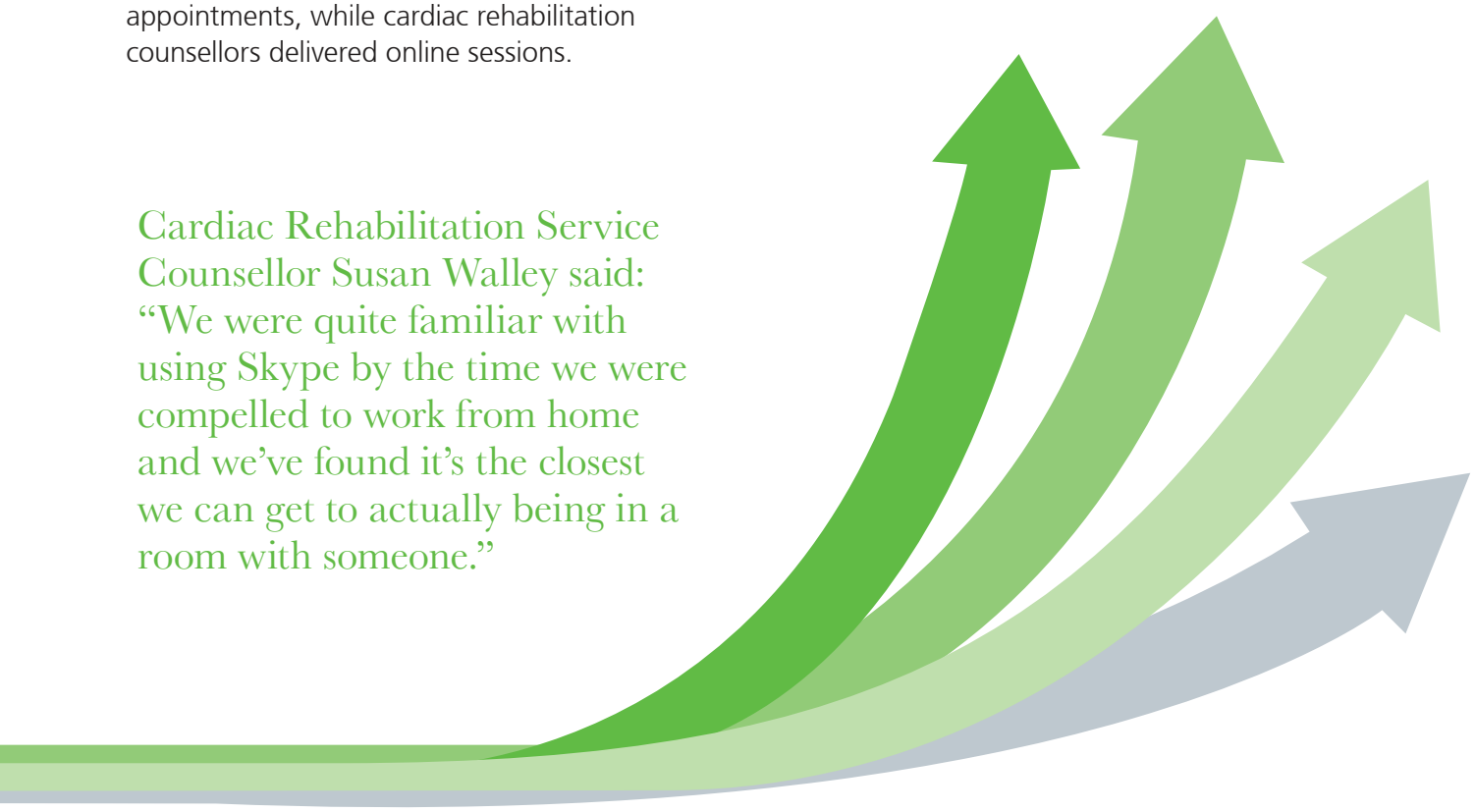
Speech and language therapists offered virtual appointments, while cardiac rehabilitation counsellors delivered online sessions.

Sexual health clinics switched to virtual ways of working. Rather than patients dropping in, they were able to send in photos of their rashes, sores, bumps or lumps, to help with assessments. The team could then phone the patient to discuss their concerns.

In December 2020, the trust began its vaccination journey with our first site for health and social care colleagues in Aylesham, which quickly included Sheppey and now our five large-scale public vaccination centres in Folkestone, Gravesend, Tonbridge, Thanet and Chatham.

Throughout this challenging year, our workforce – both frontline and support services – have remained dedicated to the people we serve. We might be doing things differently, but we are still here for our patients, every step of the way.

Cardiac Rehabilitation Service Counsellor Susan Walley said: "We were quite familiar with using Skype by the time we were compelled to work from home and we've found it's the closest we can get to actually being in a room with someone."



Engagement with the public, patients, local groups and organisations

There have been some significant and positive developments in how patients, service users and family carers work together with us to shape and deliver what we do.

In 2020, a new Participation, Engagement and Patient Experience Directorate was created to make sure patients, service users and family carers can use their own lived experiences to develop our services. The Patient and Care Partnership Team leads on all participation and engagement work in the trust. It works with our staff to develop initiatives to make sure there are opportunities for patients, service users and family carers to be involved as equal partners in the decision-making process.

Our Patient and Carer Council was established in 2020; its aim is to drive cultural changes needed in participation, co-design, shared decision-making and engagement. The council is co-chaired by our director of participation, engagement and patient experience and a patient representative. It is made up of existing patients, carers, public governors and KCHFT colleagues. The group receives reports about activities relating to participation, involvement and engagement being carried out by the trust, supports and oversees our quality priorities linked to patient, service user and family carer involvement and submits reports to the quality and workforce committees for assurance.

Our Patient Engagement Group became the new People's Network in August 2020. The People's Network carries out essential participation and engagement work in partnership with KCHFT staff and aims to engage and involve our patients in activities that promote self-care, wellness, empowerment as well as shape and design relevant services. The People's Network was involved in a number of initiatives from August 2020, including: Co-designing our complaints policy and training, shaping our quality improvement training, carer initiatives, a new Always Event project, we care visits, newsletter design, governance groups and focus groups to evaluate patient experience of care during the pandemic.

We continued to develop our carer initiatives across the trust and established our carer involvement steering group to raise awareness of the vital role carried out by unpaid carers. In November 2020, the group held a virtual carers awareness event, hosted on our social media pages, which reached more than 23,000 people. East Kent Carers Support and INVOLVE supported the event by holding a Facebook Live and Helen Whately MP, Minister for Care, shared a video message for our carers. A social media awareness event for Young Carers' Action Day was held in March 2021. The group has developed a new carers' questionnaire and will play a major role in the implementation of the Triangle of Care , which promotes the importance of involving carers, alongside service users and staff, to support recovery and sustain wellbeing.

KCHFT, supported by the Patient and Carer Partnership Team, continues to provide translation services for people whose first language is not English and interpreting services for people who have a disability, sensory loss or impairment. Video translation was rolled out across the trust in March 2020, increasing accessibility to those unable to travel during the pandemic and reaching interpreters from across the globe.

The team continued to engage with people with learning disabilities and, in partnership with East Kent Mencap, tests easy-read patient information. Throughout 2020, the group continued to meet virtually and has tested KCHFT's bereavement pack, patient appointment letters and Patient Advice and Liaison Service (PALS) contact forms for the Ask Listen Do project. This project, which aims to improve the feedback and complaints process for those with a learning disability and/or autism, has led to learning disability and/or autism awareness training for staff and the redesign of the 'your feedback' page on our website.

Our volunteers played a significant and valuable role in supporting our COVID-19 response and helping at our vaccination centres across Kent and Medway; we recruited 94 volunteers to support as stewards at these centres, along with support from more than 400 Rotary Club volunteers and 170 people from the Kent Resilience Forum.

KCHFT now has more than 550 volunteers.

Our mission, vision and values

Our mission

To **empower adults and children** to live well, to be the **best employer** and **work with our partners** as one.

Our vision

A community that **supports each other** to **live well**.

Our values

We have four values:

Compassionate

We put patients and our service users at the heart of everything we do. We're positive, kind and polite. We understand diversity. We're respectful, patient and tolerant.

Aspirational

We feel empowered and we empower our patients. We strive to improve. Our focus is on research and generating ideas and innovations. We're open, transparent and we think creatively.

Responsive

We listen. We act. We communicate clearly. We do what we say we will. We take account of the opinions of others.

Excellent

We strive to deliver the best care we can. We grow a culture of excellence in our teams. We challenge complacency.

Our goals

- Prevent ill health.
- Deliver high-quality care at home and in the community.
- Integrate services.
- Develop sustainable services.

Our priorities for 2020/21

Improve quality – innovate, improve and learn – so everyone gets the best health and wellbeing outcomes.

Support our people – engage, develop and value our people so they deliver high-quality care throughout long, rewarding careers.

Joined up care – progress partnerships so people feel supported by one multi-skilled team.

Develop our digital ways of working – invest in technology and training to give more time to care, better access to services and the power of information to all.

Reset and reimagine – follow our strong response to COVID-19 with a progressive reset plan – meet changing demand, build on positive differences and transform system working.

Our enablers

Digital – having accessible and integrated technology.

People – engaging, developing and valuing our people.

Environmental sustainability – improving our environmental impact.

System leadership – improving population health and wellbeing.

Partnership working across Kent and Medway

This past year, the health economy in Kent and Medway stood shoulder-to-shoulder, as a true integrated care partnership to provide mutual aid to each other in all its forms and save lives.

The workforce has battled with commitment and resilience that has been second-to-none – and they are the true heroes. Across the patch, primary, community, secondary and voluntary sector teams changed the way they worked and switched, with speed, to provide care at home through digital consultations.

Primary care networks, groups of GP practices and community teams worked with speed and agility to free up hospital beds to cope with huge increases in critical care.

NHS trusts supported care homes; offering digital support, infection prevention training, supplies of personal protective equipment (PPE) and swabbing; alongside delivering innovative new projects to keep residents out of hospital.

Across Kent and Medway, NHS staff moved to where help was most needed – colleagues were deployed into different roles and different trusts. Working together also resulted in better purchasing power for personal protective equipment (PPE) and made sure GPs and community pharmacy also had fast access.

New models of care developed with speed and we had a phenomenal response from our volunteers and voluntary sector workforce, thanks to our district council colleagues, who delivered prescriptions and food parcels to our most vulnerable, shielding patients.

The Salvation Army provided free refreshments at some of our sites since the start of the pandemic and companies and individuals across Kent have been generously donating treats to staff in the vaccination centres since they opened in December.

We know the challenges will continue, but this past year demonstrated that by working together we can provide better lives for the people of Kent

On 1 April 2021, Kent and Medway became an integrated care system (ICS).

Generous donations to make us smile – charity update

This year saw staggering donations to the NHS. The public weighed in with its support and we received £27,585 of generous donations on our Just Giving page.

NHS Charities Together donated £120k to help our staff through the pandemic. Who can forget the incredible Sir Captain Tom Moore and the millions he raised for NHS charities.

i care ...

KCHFT's charity i care was one of dozens throughout the NHS to receive this funding and with this money, we were able to:

- send out 1,241 colouring packs for the children of people who work for KCHFT to say thank you for supporting their parents and loved ones as they worked tirelessly through COVID-19

together

- provide a 'Together' badge for KCHFT team members to wear with pride in recognition of their efforts

- deliver a campaign that saw 3,625 colleagues claim a £10 voucher to support their health and wellbeing.

In March 2021, the charity also funded a dedicated health and wellbeing booklet for all KCHFT colleagues, and funds will be used to buy outdoor furniture for some of our sites and for services to be able to do something that supports their health and wellbeing as a team.

Going concern

The annual accounts describe KCHFT's end of year financial position and key financial performance information.

An NHS foundation trust's assessment of whether the going concern basis is appropriate for its accounts should only be based on whether it is anticipated the services it provides will continue to be provided with the same assets in the public sector.

This is expected to be the case for NHS foundation trusts unless exceptional circumstances indicate otherwise. Where the continued provision of services in the public sector is anticipated to apply, there will not be any material uncertainties over going concern requiring disclosure.

After making enquiries, the directors have a reasonable expectation the services provided by the trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

The principle risks and uncertainties facing the trust are included in the annual governance statement.

Sustainability report

In October 2020, Kent Community Health NHS Foundation Trust agreed a set of 41 actions as part of the trust's Sustainability Strategy 2021 to 2026. At the core of this strategy is a focus on the health of the communities we serve now and for generations to come. The dedicated sustainability lead position has been created to progress and report against this strategy, consistent with our commitment to the NHS Long Term Plan and Sustainability Agenda. The trust's strategy targets five broad areas: Journeys, the built environment, supply, wildlife and biodiversity, and our people (figure one).

Journeys:
By reducing non-essential travel and promoting sustainable transportation, we will contribute to cleaner air and healthier journeys.

The built environment:
By managing and designing our buildings responsibly, we will create healthier spaces for our patients and staff without reliance on burning fossil fuels.

Supply:
By sourcing products locally and supporting our suppliers and service providers to operate more sustainably, we will strengthen the resilience and economies of our communities.

Wildlife and biodiversity:
By caring for our wildlife and investing in our outdoor spaces, we will develop beautiful and healthy spaces for our patients, staff and communities to recover, work and live in.

Our people:
By supporting and empowering our amazing workforce, we will identify opportunities for beneficial change and build a culture of sustainability.

Figure one. The five core focuses areas that KCHFT focus on through the 2021/26 strategy.

Each of the 41 actions embedded within these focus areas have been designed to improve the related health, environmental and financial outcomes (figure two).

For example, we are committed to reducing the non-essential journeys connected with our operations. This is beneficial for the environment due to fewer greenhouse gas emissions being released into the atmosphere, beneficial for the trust's finances by reducing mileage claims and beneficial for health through the reduction of air pollution which is recognised to be strongly correlated with respiratory diseases.

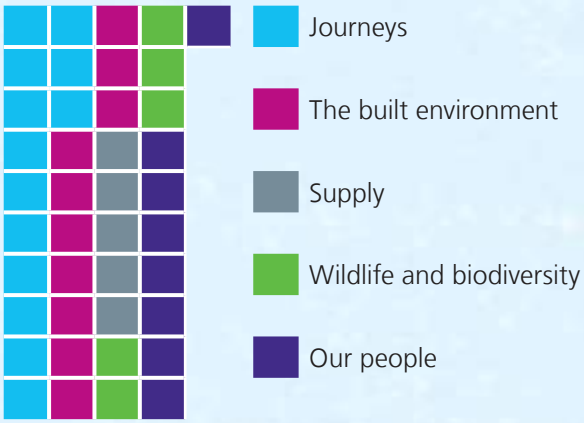


Figure two: An overview of how the 41 sustainability-focused actions for the 2021/22 targets.

Our Sustainability Strategy 2021 to 2026 details our commitment to continue to offer a healthcare provision of the highest quality in a way which will not limit our ability to do so in the future.
Our targets include:

- reduce carbon emissions attributed to journeys by supporting alternative means of travel
- measure, monitor and reduce the emissions associated with our buildings
- introduce enhanced sustainable criteria into our tendering processes so sustainability is explicitly and meaningfully considered as part of selecting suppliers
- raise awareness around the importance of green spaces and engage our communities with the creation of these spaces
- support projects identified and spear-headed by our sustainability champions.

Quantifying our journeys, estates and waste impacts

The journeys we make

- Between November 2019 and November 2020, 7.2 million miles were travelled in privately owned or leased vehicles as part of KCHFT operations, costing more than £3.2million in mileage claims.
- In March 2020, a nationwide lockdown was implemented, which affected KCHFT operations. While in February 2020 we made 756,000 miles of journeys, we saw that number reduce to 411,000 in April 2020, a reduction of 45 per cent. This reduction in mileage was consistent for the remainder of 2020 (figure three).
- The monitored reduction in staff mileage is being investigated in the context of increased virtual consultations, an increase in online training and a reduction in face-to-face meetings. This relationship shows how we can continue to deliver healthcare provision of the highest quality without the associated carbon emissions from petrol and diesel-fuelled vehicles.

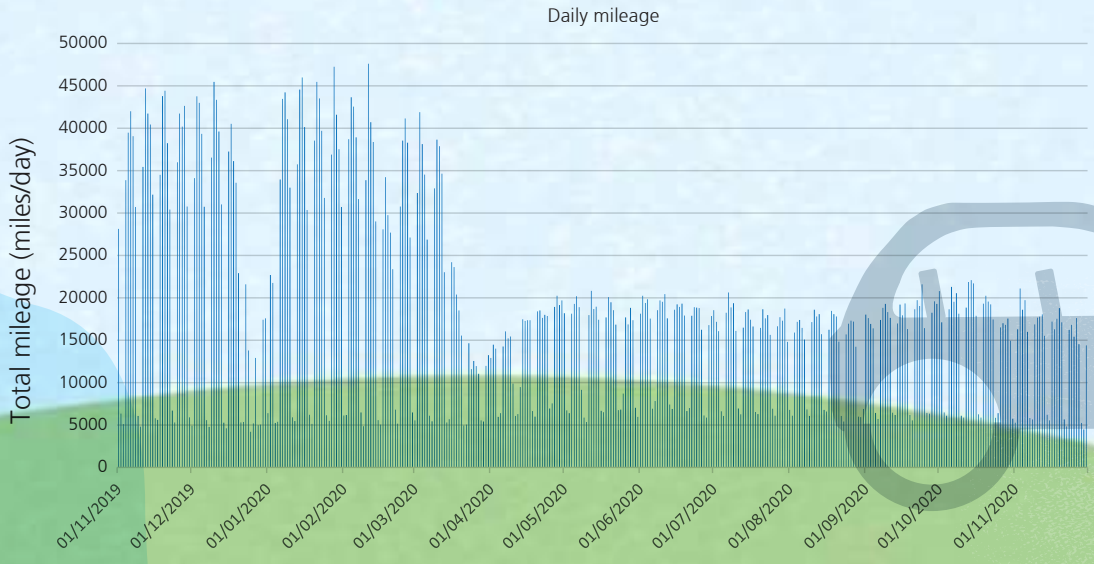


Figure three. An assessment of journeys made as part of trust operations between November 2019 and November 2020 shows the impact of the March 2020 lockdown and how we can continue to deliver healthcare provision of the highest quality without the associated carbon emissions.

The waste we generate

- The trust has worked hard to continually reduce the total quantity of waste generated across the estate and increase the percentage of waste being recycled. In 2019/20, 45 per cent of all trust waste was recycled (figure four).
- Through collaboration with other NHS trusts in the region, any waste destined for landfill is instead redirected for use in the energy from waste process. This means that no trust waste is sent to landfill.
- We are keen to continue to reduce the waste and recycling we generate as we collaborate with others to turn our waste into assets as part of the circular economy.

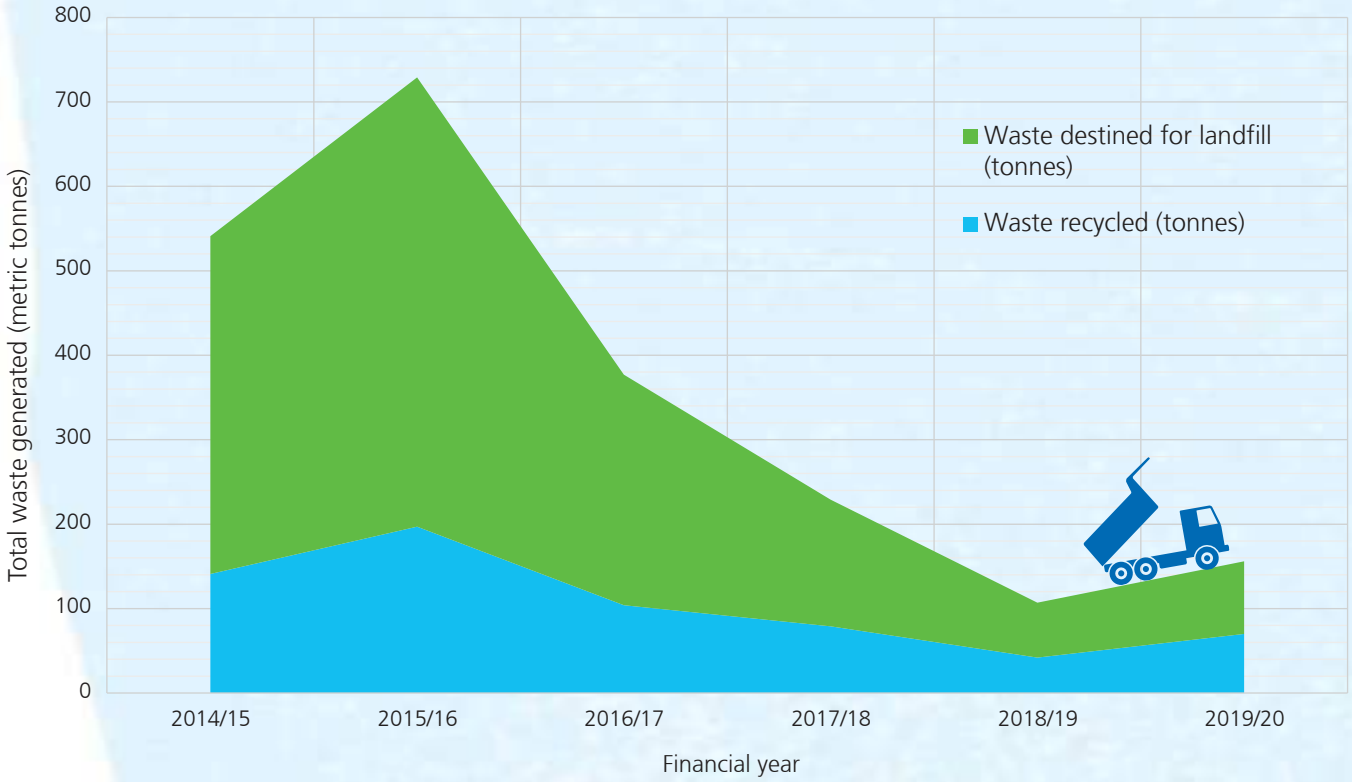


Figure four: A visualisation of the metric tonnes of waste generated by the trust from 2014/15 to 2019/20.

These figures include the waste associated with the continence service.

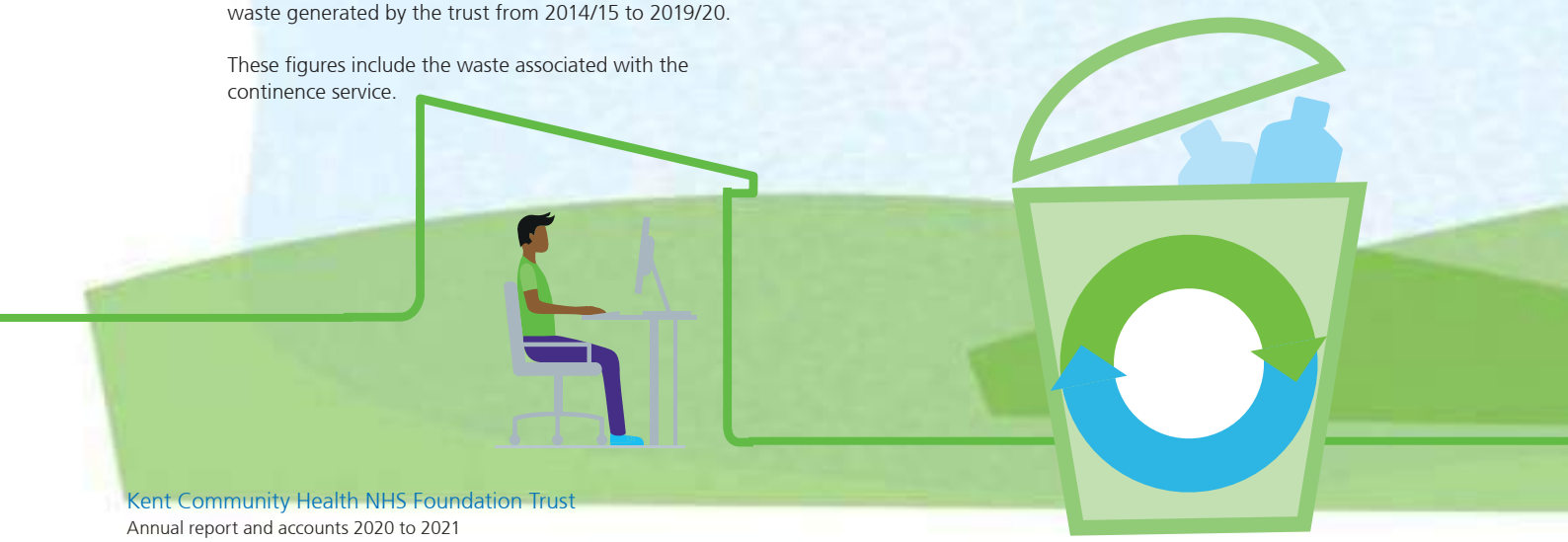
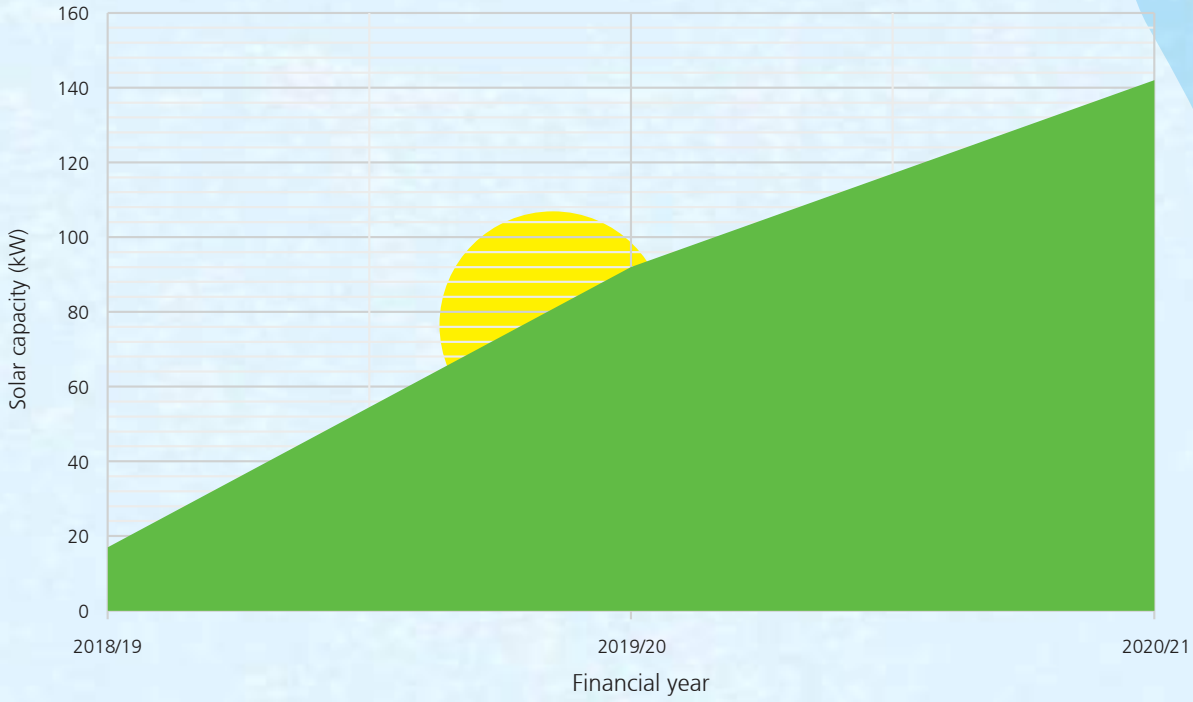


Figure five: The trust's solar generation capacity has increased from 17kW in 2018/19 to 142kW in 2020/21.

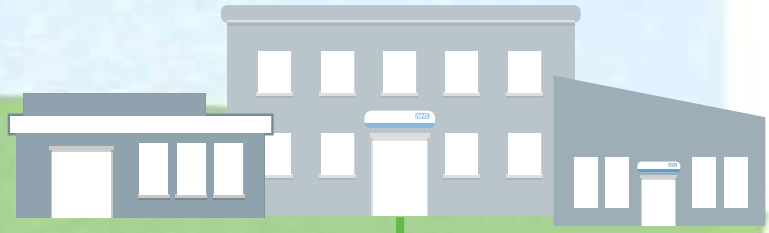


The energy we consume

- In April 2020, the trust committed to obtaining all electricity for trust sites from renewable sources using the Renewable Energy Guarantee of Origin (REGO) scheme.
- Through this initiative, it is estimated that approximately 60 per cent of energy used across trust sites will have been from a renewable source over 2020/21.
- The trust installed a new photovoltaic solar panel array at Hawkhurst Community Hospital in May 2020, increasing trust-wide solar capacity to 142kW (figure five).
- In July 2020, Hawkhurst Community Hospital became the first trust site to be energy-independent for at least one day by generating more electricity than was consumed.
- We will continue to install means of generating our own electricity across trust sites while increasing the energy efficiency of our buildings to reduce the impacts connected with powering our estate.

Signed.....

Paul Bentley,
Chief Executive Officer
Date: 17 June 2021



Accountability report

The directors' report

Board as of 31 March 2021.

Non-executive directors

Sola Afuape
Pippa Barber
Paul Butler
Peter Conway
Prof. Francis Drobniewski
Bridget Skelton
Nigel Turner

Council of Governors

Chair
John Goulston

Chief Executive
Paul Bentley

Chief Operating Officer
Pauline Butterworth

Director of Corporate Services
Natalie Davies

Director of Finance and Deputy Chief Executive
Gordon Flack

Director of Workforce, Organisational Development and Communications
Louise Norris

Medical Director
Dr Sarah Philips

Director of Strategy and Partnerships
Gerard Sammon

Chief Nurse
Dr Mercia Spare

Portfolios of executive members include:

- the chief executive: The accountable officer for the trust
- the director of finance/deputy chief executive: Leads on audit, finance, contracting, performance, information management and technology, business development and service improvement and COVID-19 vaccination
- chief operating officer: Leads on operations
- the director of workforce, organisational development and communications, organisational development and communications: Leads on workforce and organisational development, communications and engagement; executive sponsor for the Black, Asian and Minority Ethnic Staff Network
- the chief nurse: Leads on clinical strategy, quality, clinical governance and is the director of infection prevention and control and safeguarding assurance; nominated individual Care Quality Commission; Caldicott Guardian; operational senior responsible officer for COVID-19 pandemic; executive sponsor for the LGBTQ+ Staff Network
- the medical director: Leads the clinical strategy, quality, medical revalidation, clinical audit, research and development and quality improvement; executive sponsor for the Menopause Staff Network
- the director of strategy and partnerships: Leads on the development of strategy for the trust including organisational priorities. The role has a particular focus on the changes made by national policy, that of the Kent and Medway system and the trust's wider partnership work. The director also plays a key role in developing and maintaining relationships with stakeholder organisations and groups.
- the director of corporate services: Leads on regulatory framework, members and governors, governance and risk, estates, and environmental sustainability strategy
- the director of participation, experience and patient engagement: Leads on patient and carer engagement and experience; and equality, diversity and inclusion; executive sponsor for the Disability and Carers' Network.

The Board is responsible for setting the vision and strategy of the organisation and for its overall performance. This is informed by the views of the Council of Governors, following consultation with foundation trust members.

Membership of the Board is consistent with requirements of the foundation trust's constitution. The non-executive directors' skills and experience make sure there is sufficient scrutiny of executive decision-making. The Board meets in public four times a year.

The Board delegates responsibility for the day-to-day implementation of strategy to the chief executive. All board members have confirmed their support for, and adherence to, the code of conduct for NHS board members. All non-executive directors are considered to be independent.

Directors' roles and responsibilities

Executive directors

John Goulston
Trust Chair

Appointed November 2018

John is a father-of-three, from Beckenham, who has a wealth of experience working in non-executive and executive roles. John is also interim chair of Kent and Medway Sustainability and Transformation Partnership (from 1 April 2021 – Kent and Medway Integrated Care System) and chair of NHS London Procurement Partnership. Formerly, John was chief executive of both acute and community health providers. He has been an executive director of NHS London, the strategic health authority for London, plus director of finance at two London teaching hospitals during his career.

During his time as chief executive at Croydon Health Services NHS Trust, John helped establish the One Croydon Alliance, a 10-year agreement to integrate services across health and social care for all. Aimed at increasing partnership working between Croydon's NHS, GPs, the local authority and the voluntary sector in the borough, the alliance seeks to give people greater control of their health and choice of services. Much of his early career was in Kent, working in Maidstone during the 80s. John's daughter is a doctor and his wife is a community physiotherapist.

- Chair of Remuneration and Terms of Service Committee.

Paul Bentley
Chief Executive

Appointed March 2016

Paul Bentley – named as one of the top NHS chief executives in the country by the Health Service Journal in 2021 – has held the position of chief executive of Kent Community Health NHS Foundation Trust since 1 March 2016.

Under Paul's leadership, KCHFT has held an 'outstanding' rating by the Care Quality Commission since 2019. In 2021, staff rated the organisation among the best in the country to work for in the annual NHS staff survey results and as one of the highest performing community trusts in the country in five areas.

Paul has spearheaded improvements in patient satisfaction and staff engagement, as well as making sure the trust remained in financial balance; he is proud these have been delivered and enabled teams to work in different ways rather than be told what to do.

Passionate about partnerships, Paul is a key player in the Kent and Medway Integrated Care System and the development of integrated care partnerships. He is the senior responsible officer (SRO) for the east Kent integrated care partnership, as well as SRO for community services transformation across the south east and is leading work to improve care for people with learning disabilities and autism in Kent and Medway; this is something he feels passionate about. He has also led the trust to sign partnership agreements with Kent County Council and Kent and Medway Health and Social Care Partnership.

A father of three grown-up young people, Paul has a wealth of experience of not only NHS healthcare, but has also studied in the US. Before joining KCHFT, Paul was Director of Workforce and Communications at Maidstone and Tunbridge Wells NHS Trust since 2011.

He has worked in the NHS since 1987 and as an NHS director since 1998 at various times leading on strategy, organisational development and workforce and communications. During this time, he was also interim chief executive of an acute trust in Surrey, and held the position of non-executive director for NHS innovations South East.

He lives in south west London with his wife and dog. There is no escaping health as Paul's wife also works as a health consultant and his daughter is a junior doctor. His two sons haven't followed in their parents' footsteps, although they have both overtaken him when running half-marathons.

Paul is passionate about KCHFT delivering high-quality care for all and believes it's important for colleagues to have a work life balance. In his spare time, Paul enjoys time with his family, and running to try and stay fit, including completing half marathons; he is also a long suffering supporter of Gloucester Rugby Club.

Pauline Butterworth
Chief Operating Officer

Appointed December 2019

Pauline, who is originally from Carnoustie, Scotland, joined the trust from East Sussex Healthcare Trust where she was the deputy chief operating officer since 2013. During that time, she was also programme director for transformation of urgent care at Hastings and Rother and Eastbourne and Seaford Clinical Commissioning Group. A trained clinician, Pauline worked as a therapist and manager in the USA and in paediatrics in Australia, before returning to the UK. She started with the NHS in 2008 and has worked across a breadth of services, including community, acute and commissioning, as well as social care.

- Member of Finance, Business and Investment Committee.
- Member of Quality Committee.
- Member of Strategic Workforce Committee.

Ali Carruth
Director of Participation, Engagement and Patient Experience

Appointed January 2020; previously Chief Nurse (Board)

Ali qualified as a registered general nurse in 1994. She completed a number of postgraduate studies and qualified as a registered mental health nurse in 2004. Ali graduated from the NHS Leadership Academy Nye Bevan Executive Healthcare Leadership Award in 2014. She has worked in the NHS for more than 30 years holding a variety of senior nursing posts in a number of trusts in London, Devon, Kent, Surrey and Sussex and as an executive director for more than seven years. Ali is passionate about making sure patients and their carers are equal partners in their care and receive the best experience possible while using our services. She has a clinical background in acute, community and mental health nursing, as well as holding a national position with NHS England providing clinical leadership to the National Ebola Team.

Ali lives in West Sussex with her wife and children.

Natalie Davies
Director of Corporate Services and Trust Secretary

Appointed 2015

Natalie has worked within the NHS in both acute and community settings for more than 20 years. As the corporate services director, Natalie has a strong background in corporate governance, risk management and compliance. Natalie has primary responsibility for a number of areas, including estates, facilities, legal, risk, compliance and environmental sustainability.

In addition to spending time with her two boys, Natalie has a number of hobbies including working with local acting groups.

- Natalie is a non-voting member of the Board.

Gordon Flack
Executive Director of Finance and Deputy Chief Executive

Appointed 2011

Gordon is a fellow of the Chartered Association of Certified Accountants (FCCA) and has a professional background in NHS finance spanning 37 years. Following an early career with health authorities, his director experience is with acute and community trusts and has been at the trust since 2011. His responsibilities include financial management and control, capital and audit, IM&T, business development and service improvement, as well as performance and business intelligence. Gordon lives in Essex with his wife and two sons and is keen on gliding and sailing.

- Member of Finance, Business and Investment Committee.

Louise Norris
Director of Workforce, Organisational Development and Communications

Appointed July 2015

Louise has more than 30 years' experience in NHS human resources and has worked at regional, trust and primary care level. She is a Fellow of the Chartered Institute of Personnel and Development. She has an MBA and an MA in strategic human resources. She is a management side representative on the NHS Staff Council.

Louise lives with her husband in West Malling.

- Member of Strategic Workforce Committee.

Dr Sarah Phillips
Medical Director

Appointed 2017

Sarah is a GP at Newton Place Surgery in Faversham, Kent. Before joining the trust as the medical director, Sarah was clinical chair of Canterbury and Coastal Clinical Commissioning Group and chair of East Kent Strategy Board. The board was set up by local health and care commissioners to spearhead the drive to determine how best to provide health and care services to the population of east Kent. Its work was part of the wider Sustainability and Transformation Plan (STP) for Kent and Medway. Sarah's work on this board included reviewing issues around staff retention, the use of technology, buildings and estates, and clinical pathways such as maternity, paediatrics, end-of-life care and mental health.

Until April 2017, Sarah was also commissioner co-chair of Kent and Medway Sustainability and Transformation Partnership Clinical Board, which was set up to make sure the NHS future plans met the health and social care needs of the communities it serves.

Sarah lives in Canterbury with her two children. She is also a keen tennis player.

- Member of Quality Committee.

Gerard Sammon
Director of Strategy and Partnerships

Appointed January 2020; previously director of strategy October 2018 (Board).

Before joining KCHFT, Gerard had spent more than 20 years in a number of NHS board and leadership roles including serving as an interim chief executive. In previous posts, he led system-wide changes and programmes of work with other health and care organisations that spanned north Kent and south east London and pioneered the introduction of group models into the NHS. He previously studied at King's College London, Ashfridge Business School and was a member of the NHS Top Leaders Programme.

He is keen on coaching youth basketball and is married with three children.

- Member of Finance, Business and Investment Committee.

Dr Mercia Spare
Chief Nurse

Appointed January 2020; previously interim chief nurse

Mercia joined as permanent chief nurse in January 2020 following a 13-month secondment from NHS Improvement. Mercia has worked in the health service for 35 years and describes herself as a 'passionate champion of the NHS and the values it embodies'. Her clinical experience includes transplantation, coronary care, renal and cardiothoracic nursing. Mercia holds a Batchelor of Science degree in applied and human biology and a doctorate in clinical research. During her career, Mercia has held a number of senior leadership roles within the NHS at both an operational and strategic level. She has led a number of large scale national improvement projects and supported the development of a range of tools that have focused on improving the safety of patients. She has worked for a number of provider organisations including University Hospitals Birmingham NHS Foundation Trust, the Department of Health, the Trust Development Authority and NHS Improvement.

- Member of Charitable Funds Committee.
- Member of Quality Committee.
- Member of Strategic Workforce Committee.

Non-executive directors

Sola Afuape
Non-executive Director

Appointed December 2019

Sola has 20 years' experience advising, designing and implementing national, regional and local public sector programmes most notably delivering health inequalities and service improvements. She has been a chair of a national charity tackling social and health inequalities with a particular focus on mental health, for which she was awarded an MBE.

In the early part of her career, she held a number of advisory roles and worked across the Department of Health, Public Health England, Standing Commissioning on Carers and the Arts and more recently across a collaboration of CCGs as a lay advisor in integrated care and transformational workforce and organisation development.

She runs her own consultancy specialising in strategy, organisational development and equalities and conducting independent reviews across health and social care and the wider public sector for organisations such as CafCass and the Nursing and Midwifery Council. She is also a special advisor for the Care Quality Commission and independent member of HMRC's London Advisory Committee.

Sola has a deep passion for the wellbeing of patients, their families and carers, staff and citizen voice, co-production and systems leadership.

- Member and deputy chair of Charitable Funds Committee.
- Member of Finance, Business and Investment Committee.
- Member of Quality Committee
- Member of Remuneration and Terms of Service Committee.
- Non-executive director lead for freedom to speak up.

Pippa Barber
Non-executive Director

Appointed December 2016

Pippa Barber brings a wealth of experience with a strong clinical background and focus on governance, quality and improvement from nearly 40 years' experience in the NHS. She has spent the past 20 years in various board roles including most recently as a non-executive director. Pippa has significant past experience working in senior clinical roles including chief nurse and director, with a number of different organisations across the system – acute, community, primary care, clinical network, mental health and commissioning.

She also works as the independent nurse for a clinical commissioning group in London, where she maintains an essential focus on system learning, health inequalities, quality and performance and is a trustee for a Kent-based charity.

Pippa lives in Kent.

- Chair of Quality Committee.
- Member; and deputy chair of Audit and Risk Committee.
- Member of Charitable Funds Committee.
- Member of Remuneration and Terms of Service Committee.
- Non-executive director lead for mortality and learning from deaths.

Paul Butler
Non-executive Director

Appointed March 2020

Paul is a chartered accountant with extensive management, financial and regulatory experience.

From 2001 to 2020, Paul had been Managing Director of Mid Kent Water and subsequently South East Water. Previously, Paul worked as group financial controller of Mid Kent Water and he has been a non-executive director of Water UK, the water industry trade body and chair of UKWIR, a research organisation for the water sector.

- Chair of Finance, Business and Investment Committee.
- Member of Remuneration and Terms of Service Committee.

Peter Conway
Non-executive Director and Vice Chair (from May 2019)

Appointed March 2015

Peter has a professional background in banking and finance spanning 28 years, latterly as a finance director with Barclays Bank PLC. He has been a non-executive director with the NHS since 2006. He has held a portfolio of public sector roles including:

- Non-executive director and audit chair, Rural Payments Agency.
- Non-executive director and audit chair, NHS West Kent.
- Independent member of the Audit Committees of the Home Office, Ministry of Justice, DEFRA, Health and Safety Executive and Child Maintenance and Enforcement Commission.
- Trustee director, Citizens Advice North and West Kent.
- He was appointed as a non-executive director with Kent and Medway NHS and Social Care Partnership Trust in 2020.
- Chair of Audit and Risk Committee.
- Member of Finance, Business and Investment Committee.
- Member of Remuneration and Terms of Service Committee.

Professor Francis Drobniewski
Non-executive Director

Appointed October 2018 (Designate); February 2019 (Board)

Professor Francis Drobniewski divides his time between clinical practice, education and research. He is professor of global health and tuberculosis (TB) at Imperial College, London, a consultant medical microbiologist and was a tuberculosis physician. He has worked in Europe, USA and Africa focussing on tuberculosis and other respiratory infections, HIV and antimicrobial resistance, and was director of the public health UK National TB Laboratory for 19 years. Francis was clinical TB adviser for the National Institute of Clinical Excellence (NICE) until recently and an advisor to the World Health Organisation (WHO).

Having spent 20 years as a consultant, Francis is keen to do more in strategic development of health services and public health. He has worked in acute services and public health and with community services and believes in keeping people out of hospital wherever possible.

- Chair of Charitable Funds Committee.
- Member and deputy chair of Quality Committee.
- Member of Strategic Workforce Committee.
- Member of Remuneration and Terms of Service Committee.
- Non-executive director end of life champion.

Bridget Skelton
Non-executive Director

Appointed March 2015

Bridget Skelton has 25 years' experience as a senior executive and board member in organisations in the legal, financial, management consultancy, retail, public and voluntary sectors. She brings particular know how to effect business transformation, enhance performance and manage cultural development and change. Bridget lives in rural Kent.

- Senior independent director
- Chair of Strategic Workforce Committee.
- Member of Audit and Risk Committee.
- Member and deputy chair of Finance, Business and Investment Committee.
- Member and deputy chair of Remuneration and Terms of Service Committee.

Nigel Turner

Non-executive Director

Appointed October 2018

Nigel is a group human resources director with a proven track record in leading transformational people-change in some of the most challenging recent UK organisational scenarios. His career has included leading the operational people agenda of the modernisation/privatisation of Royal Mail for the 140,000 UK nation's postal workers. He led the people agenda of the Argos digital transformation and sale to Sainsbury's, Spire Healthcare's recovery and also provided strategic support to the Board at Northern Rock following the financial crisis. Nigel also consults on change with Jaguar Landrover, a current and major client.

He lives in Harrietsham, near Maidstone.

- Member of Quality Committee.
- Member and deputy chair of Strategic Workforce Committee.
- Member of Remuneration and Terms of Service Committee.

Board and committee attendance

Board, committee and Council of Governor meetings continued throughout the pandemic and were carried out virtually. Virtual Board and Council of Governor meetings were made available to the public by MS Teams live event or recordings available on the trust's website.

Where a director is unable to attend a meeting s/he receives papers in advance and has the opportunity to provide comments to the chair of the Board, or to the relevant committee chair.

	Audit and Risk Committee		Charitable Funds Committee		Council of Governors		Finance Business and Investment Committee		Formal Board		Quality Committee		Strategic Workforce Committee	
Non-executive directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Sola Afuape	0	3	3	3	0	2	6	5	9	7	8	6*	0	3
Pippa Barber	4	4	3	3	0	2	0	2	9	9	8	8	0	2
Paul Butler	0	1	0	0	0	3	6	6	9	9	0	2	0	0
Peter Conway	4	4	0	0	0	0	6	5	9	9	0	2	0	4
Prof Francis Drobniewski	0	2	3	3	0	1**	0	1	9	8	8	7	6	6
John Goulston	0	1	0	0	3	3	0	4	9	9	0	4	0	2
Bridget Skelton	4	3	0	1	0	2	6	6	9	9	0	3	6	6
Nigel Turner	0	0	0	0	0	1	0	0	9	9	8	8	6	6

Executive directors	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**	**A**	**B**
Paul Bentley	0	1	0	0	0	2	0	4	9	8†	0	1	0	0
Pauline Butterworth	0	1	0	0	0	1	6	6	9	9	8	6	6	6
Natalie Davies	0	4	0	0	0	3	0	5	9	9	0	0	0	1
Gordon Flack	0	3	0	1	0	1	6	5	9	9	0	0	0	0
Louise Norris	0	0	0	1	0	1††	0	0	9	9	0	1	6	6
Dr Sarah Phillips	0	0	0	0	0	0	4	3	9	9	8	7	0	2
Gerard Sammon	0	0	0	0	0	0	6	6	9	9	0	0	0	0
Dr Mercia Spare	0	0	3	1	0	1‡	0	0	9	9	8	7	6	4

A total number of meetings the director was eligible to attend as a member of the committee.
B total number of meetings the director did attend.

* Sola Afuape attended all Quality Committee meetings but did not attend the two extraordinary committee meetings.
** Prof. Francis Drobniewski was on sick leave for one meeting.
† Paul Bentley was on sick leave for one meeting.
†† Louise Norris sent a representative for one meeting.
‡ Dr Mercia Spare sent a representative for one meeting.

Directors' report: Compliance statements

The directors' register of interests is available on the trust's website www.kentcht.nhs.uk

The Board and Council of Governors comply with the fit and proper persons test.

The trust has in place a major incident plan that is fully compliant with the requirements of the NHS England Preparedness, Resilience and Response Framework 2015. The trust regularly participates in exercises and training with public sector partners. The trust's internal auditor produces an annual internal audit plan, which reviews the economy, efficiency and effectiveness of resources. The work programme is agreed and monitored by the Audit and Risk Committee.

Better payment practice code 2020/21

The trust complies with the Better Payment Practice Code (BPPC) which, requires NHS organisations to pay all creditors within 30 days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

The trust's compliance with the BPPC for 2020/21 is set out here:

Non-NHS payables	2020/21 number	2020/21 £000s
Total non-NHS trade invoices paid in the period	32,741	82,280
Total non-NHS trade invoices paid within target	32,268	81,258
Percentage of non-NHS trade invoices paid within target	98.56%	98.76%

NHS payables	2020/21 number	2020/21 £000s
Total NHS trade invoices paid in the period	1,729	17,464
Total NHS trade invoices paid within target	1,564	15,064
Percentage of NHS trade invoices paid within target	90.46%	86.26%

Total

Total non-NHS and NHS trade invoices paid in the period	34,470	99,744
Total non-NHS and NHS trade invoices paid within target	33,832	96,322
Percentage of non-NHS and NHS trade invoices paid within target	98.15%	96.57%

The trust is a signatory of the Prompt Payment Code (PPC) which sets standards for payment practices and best practice and is administered by the Chartered Institute of Credit Management.

Throughout 2020/21, the trust has also aligned with Cabinet Office direction to ensure prompt payment practices in response to the COVID-19 pandemic.

Council of Governors as at 31 March 2021

Public governors

Ashford
Kathy Walters

Canterbury
Lynne Spencer

Dartford
Elaine Ashford

Dover/Deal
Carol Coleman

Gravesham
Dot Marshall

Maidstone
David Price

Sevenoaks
Gillian Harris

Folkestone and Hythe
Hodgson Birkby

Thanet
Jane Hethington

Rest of England
John Woolgrove

Swale
Miles Lemon

Tunbridge Wells
Loretta Bellman

Tonbridge and Malling
Ruth Davies

Staff governors

William Anderson
Adult Services

Dawn Gaiger
Adult Services

Jan Allen
Corporate Services

Maria-Loukia Bratsou
Children and Families

Kimberley Lloyd
Health and Wellbeing

Appointed governors

Dr Susan Plummer
Universities

Andrew Scott-Clark
Public Health

Nigel Stratton
Age UK

Matthew Wright
Head Teachers' Association

Alison Carter
Kent Dementia Action Alliance

Governors are elected for a period of three years.

Membership: Representation and effectiveness

The trust agreed a membership strategy for 2018 to 2021, which set out four objectives, linked to our communication and engagement goals, to make sure our members were fully informed and involved.

The action plan set against these objectives is monitored by the governors' Communications and Engagement Committee.

The four objectives are:

1. to provide members with accurate information about our services and how to improve on their health and wellbeing
2. to increase opportunities for membership to feedback on our services and make sure these are fed into service design and improvement
3. to increase membership levels by two per cent year-on-year (with a stretch target of five per cent) and make sure our membership reflects the population that we serve
4. to make sure members know who their local governor is, what they do/their role and why and how to contact them.

Understanding the views of governors and members

Throughout 2020/21, governors were kept up-to-date virtually via the Council of Governors meetings, development sessions, informal monthly governor update meetings, as well as sharing of information via email. The new governor induction was also conducted virtually. The trust continued to support governors to make sure they were able to develop their role, represent their constituents and hold the trust to account for its performance.

Governors are invited to at least one full-day development session each year, as well as four morning sessions held before the council meetings. The development session planned for April 2020 was cancelled due to the COVID-19 pandemic, but all other sessions took place virtually and were well attended by governors. These sessions are devoted to a range of topics, including service presentations and board committee deep dive discussions.

Under ordinary circumstances, governors would usually be invited to attend a number of trust visits, internal reviews and engagement events in person throughout the year. However, due to the pandemic most of these events did not take place during 2020/21.

Instead, the trust embraced virtual meetings and governors were invited to observe board meetings and other events, such as the Patient and Carer Council meetings, using MS Teams.

During 2020/21, our governors carried out a number of statutory duties, including the approval of the remuneration and appraisal process for the chair and non-executive directors and the approval of the contract extension for the external auditor.

Governor support staff from Kent and Medway foundation trusts continued to meet virtually on a quarterly basis, to share best practice, discuss matters of interest and concern and to make sure they could offer a good and consistent support mechanism for their members.

Remuneration report

This presents information from the 1 April 2020 to 31 March 2021.

Annual statement on remuneration

Information not subject to audit.

The chief executive and medical directors' performance against the agreed objectives was discussed by the Remuneration Committee. These were met in full and consequently the committee agreed there would be no claw back of salary. In addition, performance related pay was agreed for the chief executive and deputy chief executive

There were no other substantial changes relating to senior managers' remuneration made during the year.

The Council of Governors reviewed the salaries for the chair and the non-executive directors in January 2021 and it wished to maintain the remuneration at the current levels.

Senior managers' remuneration policy

Policy on remuneration for executive directors

The Remuneration Committee determines the salaries of the chief executive and the other executive directors by considering market rates. Existing Trust Very Senior Manager (VSM) contracts and notice periods of six months follow the VSM guidance from the Department of Health and Social Care.

Notice periods for all very senior managers hired after 1 March 2015 is three months. Notice periods should normally be worked to make sure the NHS receives benefit during the notice period. This could include carrying out special projects and short term placements.

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
Senior managers are entitled to a basic salary which is determined by the Remuneration Committee. The rates paid to individual directors are determined by the Remuneration Committee, which takes into account: • qualifications required for the role • spans of responsibility and accountability • performance • market forces	The trust believes its senior managers should be fairly remunerated for their work. Trust salaries should be competitive and enable the trust to attract, and in due course, retain high calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will therefore reference its salaries to the NHS Providers survey of executive salaries and independent advice as required.	Salaries are reviewed against external NHS benchmarking and set at the lower end of the upper quartile for similar organisations, taking into account other factors including performance and qualifications. In the case of any salary above £150,000 the views of ministers are sought. A claw back scheme is in place for the medical director's salary. Should objectives not be achieved the salary is reduced by 10 per cent. A report is presented to the Remuneration Committee.	
The annual uplift		A cost of living award of £1,067 and a non-consolidated bonus equal to an overall 1.67 per cent in line with what was implemented for Agenda for Change for those at the top of band 8d and 9.	1.67 per cent of which only £1,067 was consolidated

Pay component	How that component supports the trust's short and long-term strategy	How it operates	Maximum payable
Chief executive earn back	The trust believes the chief executive should be properly remunerated for their work. Trust salaries should be competitive and enable the trust to attract high calibre staff. However, salaries should not be overly high and should be positioned in the top quartile of salaries for similar organisations. The Remuneration Committee will therefore reference its salaries to the NHS Providers survey of executive salaries and independent advice, as required. Where applicable views of ministers are sought.	A claw back scheme is in place. Should objectives not be achieved the salary is reduced by 10 per cent.	10 per cent of salary
Performance related pay	To make sure the delivery of the trust strategic objectives a bonus payment can be made to the chief executive and deputy chief executive.	On the achievement of objectives.	Up to £17K

Each contract for directors gives the trust the right to deduct from a director's salary, or any other sums owed, any money owed to the trust. If, on termination of the appointment, the director has taken in excess of their accrued holiday entitlement, the trust shall be entitled to recover by way of deduction from any payments due. No provisions for the recovery of sums paid or for withholding of sums to senior managers have been made in the period. The trust's policy on senior managers' remuneration and its general policy on employees' remuneration differ only, in so far as other staff are on the Agenda for Change or Medical and Dental pay scales, while directors' pay is determined outside of this framework.

Policy on remuneration for non-executive directors

The remuneration for non-executive directors (NEDs) is set by the Council of Governors. No 'golden hellos', compensation for loss of office or other remuneration from the trust was paid during 2020/21. Non-executive members do not receive pensionable remuneration.

The Council of Governors determines the pay for the chairman and non-executive directors and in doing so, take into account comparative remuneration of other foundation trusts. They are on fixed term, renewable contracts. There is no compensation for early termination.

There are three levels of remuneration based on the level of commitment expected of the post holder: Trust chairman; chair of audit and risk, quality and finance, business and investment committees, strategic workforce committee; other non-executive directors.

Pay component	Description	Application
Chair basic pay	A spot rate salary £46,500	Trust's chair
Non-executive basic pay	A spot rate salary £13,800 for NEDs appointed before September 2019. For those appointed after this date £13,000 in line with NHSI guidance.	Five NEDs Two NEDs
NED committee – chair responsibility	20 per cent uplift.	Quality Committee chair Strategic Workforce Committee chair Audit and Risk Committee chair Finance, Business and Investment Committee chair

Service contracts obligations

There is one standard contract for all directors. The chief executive and medical directors' contracts includes a clause regarding claw back. In addition, the chief executive and deputy chief executives' contracts include performance related pay. This standard contract puts the following obligations on the trust:

- review performance annually
- give reasonable notice of any variation to salary
- any redundancy payment will be calculated in accordance with paragraphs 16.8 and 16.9 of the NHS terms and conditions of service handbook
- to pay appropriate expenses incurred in the course of duties in accordance with the trust's Travel and Expenses policy
- annual leave follows standard NHS terms, likewise sickness
- the notice period for all executive directors appointed post April 2015 except the chief executive is three months. The chief executive has to give six months' notice
- no executive director is on a fixed term contract.

Policy on loss of office

- notice periods as above for resignation for chief executive and all directors
- payments in lieu of notice are at the discretion of the trust
- senior manager's performance is relevant for loss of office when a material element of the business plan has not been delivered and then there can be dismissal without notice.

Setting senior managers' remuneration policy

The pay and conditions of employees (including any other group entities) were taken into account when setting the remuneration policy for senior managers.

The trust did not consult with employees when preparing the senior managers' remuneration policy.

The chief executive confirms the remuneration report covers senior managers who have authority or responsibility for directing or controlling the major activities of the trust. These managers influence the decisions of the entity as a whole rather than the decisions of individual directorates or department.

The policy on diversity and inclusion used by the remuneration committee

As an employer for, and a provider of, health services in Kent, London and East Sussex the Remuneration Committee takes the issues of fairness, rights and equality very seriously.

The committee carries out an equality impact assessment on all polices and decisions.

Annual report on remuneration

Information not subject to audit.

Remuneration Committee

The committee is a formal committee of the Board. The purpose of this committee is to advise the Board on all aspects of the remuneration and terms of conditions for the chief executive, executive directors and directors reporting to the chief executive making sure these properly support the objectives of the trust, represent value for money and comply with statutory requirements.

The committee's members are the non-executive directors of the trust and the committee is chaired by the trust's chair. Between 1 April 2020 and 31 March 2021 there were four meetings of the Remuneration Committee.

Remuneration Committee	Meetings attended 2020/21
John Goulston	4
Peter Conway	4
Bridget Skelton	4
Pippa Barber	4
Francis Drobniewski	4
Nigel Turner	4
Paul Butler	2
Sola Afuape	2

The chief executive and director of workforce, organisational development and communications also attend meetings by invitation; however, they are not present where matters relating to them are under discussion. Bevan Brittan and Capsticks have provided legal advice in relation to employer's pension contributions opt-out policy.

This committee determines the remuneration and conditions of service of the chief executive, other directors and senior managers with Board responsibility who report directly to the chief executive, making sure these properly support the objectives of the trust, represent value for money and comply with statutory requirements. The committee does not determine the remuneration of the non-executive chair and the non-executive directors, which is set by the Council of Governors.

Service contracts

Executive director service contracts are permanent with the following notice periods:

Senior manager	Date effective	Notice
Paul Bentley, Chief Executive Officer	1 March 2016	6 months
Pauline Butterworth, Chief Operating Officer	16 December 2019	3 months
Ali Carruth, Director of Quality Improvement and Patient Experience	6 January 2020	3 months
Natalie Davies, Director of Corporate Services	1 April 2015	3 months
Gordon Flack, Director of Finance and Deputy Chief Executive Officer	1 March 2015	6 months
Louise Norris, Director of Workforce, Organisational Development and Communications	7 July 2015	3 months
Sarah Phillips, Medical Director	10 April 2017	3 months
Gerard Sammon, Director of Strategy and Partnerships	1 October 2019	3 months
Mercia Spare, Chief Nurse	1 January 2020	3 months
Lesley Strong, Chief Operating Officer and Deputy Chief Executive Officer (to 05/12/19), Returned to Executive Team 16/03/20 to 31/07/20.	16 March 2020	3 months

Non-executive director service contracts are fixed-term with the following unexpired terms as at the 31 March 2021:

Non-executive directors	Date effective	End date	Unexpired term
John Goulston, Chair	1 November 2018	31 October 2021	7 months
Peter Conway, Vice Chair	1 April 2018	31 March 2022	1 year
Sola Afuape, Non-executive Director	1 December 2019	30 November 2022	1 year, 8 months
Pippa Barber, Non-executive Director	1 December 2019	30 November 2022	1 year, 8 months
Paul Butler, Non-executive Director	1 March 2020	28 February 2023	1 year, 11 months
Francis Drobniewski, Non-executive Director	1 October 2018	31 January 2022	10 months
Bridget Skelton, Non-executive Director	7 April 2019	6 April 2022	1 year
Nigel Turner, Non-executive Director	1 October 2018	30 September 2021	6 months

Peter Conway's contract was extended within the year by an additional year; this was approved by the Council of Governors.

Expenses of senior managers and governors

The following expenses were paid to senior managers in the period:

Directors and senior managers	Expenses* (rounded to nearest 100) £00	
	2020/21	2019/20
Paul Bentley, Chief Executive Officer	4	13
Lesley Strong, Chief Operating Officer/Deputy CEO (to 05/12/19), Returned to Executive Team 16/03/20 to 31/07/20	1	17
Pauline Butterworth, Chief Operating Officer (from 16/12/19)	1	1
Gordon Flack, Director of Finance and Deputy CEO	–	15
Ali Carruth, Chief Nurse (to 05/01/20), Director of Quality Improvement and Patient Experience (from 06/01/20)	–	–
Mercia Spare, Chief Nurse	3	3
Sarah Phillips, Medical Director	2	22
Natalie Davies, Director of Corporate Services	–	10
Louise Norris, Director of Workforce, OD and Communications	1	17
Gerard Sammon, Director of Strategy and Partnerships	2	18
John Goulston, Chairman	9	32
Richard Field, Vice Chairman (to 30/04/19)	–	2
Peter Conway, Vice Chairman (from 01/05/19)	3	10
Sola Afuape, Non-executive Director (from 01/12/19)	2	11
Pippa Barber, Non-executive Director	–	23
Paul Butler, Non-executive Director (from 01/03/20)	–	–
Martin Cook, Non-executive Director (from 01/10/18 to 30/09/19)	–	4
Francis Drobniewski, Non-executive Director	5	14
Steve Howe, Non-executive Director (to 30/04/19)	–	3
Bridget Skelton, Non-executive Director	2	7
Jennifer Tippin, Non-executive Director (to 01/03/20)	–	–
Nigel Turner, Non-executive Director	5	–
Total	40	222

There were a total of 18 executive and non-executive directors in post in the reporting period 2020/21 and 13 of these received expenses paid by the trust. The aggregate sum of directors' expenses totals £4,001.75.

The following expenses were paid to governors in the period:

Governors	Expenses (rounded to nearest 100) £00	
	2020/21	2019/20
Jo Clifford	–	2
Carol Coleman	2	10
Ruth Davies	–	2
John Fletcher	–	3
John Harris	–	1
Miles Lemon	1	2
David Price	–	3
Anthony Quigley	–	1
Nigel Stratton	–	1
Total	**3**	**25**

There are a total of 23 governor positions. There have been 27 individuals working as governors within the year, with four leaving and seven starting in the period. As of 31 March 2021, there are 23 governors in post, with no vacant positions. In the reporting period 2020/21, two governors received expenses paid by the trust.

The aggregate sum of governors' expenses totals £345.75.

The remaining information in this report is subject to audit

Name and title	2020/21						2019/20					
	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total
	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
Paul Bentley, Chief Executive Officer	205–210				505–507.5	715–720	185–190				0	185–190
Lesley Strong, Chief Operating Officer/Deputy CEO (to 05/12/19), Returned to Executive Team 16/03/20 31/07/20	20–25		0–5		0	20–25	95–100				0	95–100
Pauline Butterworth, Chief Operating Officer (from 16/12/19)	130–135		0–5		50–52.5	185–190	35–40				10–12.5	45–50
Gordon Flack, Director of Finance and Deputy CEO (Deputy CEO from 01/12/19)	160–165		0–5		0	165–170	150–155	2,500			0	155–160
Ali Carruth, Chief Nurse (to 05/01/20), Director of Quality Improvement and Patient Experience (from 06/01/20)	75–80		0–5		0	75–80	60–65				0–2.5	65–70
Mercia Spare, Interim Chief Nurse (from 26/11/18 to 31/12/19), Chief Nurse (from 01/01/20)	125–130		0–5		90–92.5	215–220	110–115				122.5–125	230–235
Sarah Phillips, Medical Director	170–175				25–27.5	195–200	175–180				52.5–55	230–235
Natalie Davies, Director of Corporate Services	105–110		0–5		12.5–15	120–125	100–105				45–47.5	150–155
Louise Norris, Director of Workforce, OD and Communications	120–125		0–5		37.5–40	160–165	120–125				42.5–45	160–165
Gerard Sammon, Director of Strategy and Partnerships	140–145		0–5		170–172.5	315–320	125–130				0	125–130

*The annual performance-related bonuses are non-consolidated bonuses issued in line with the annual uplift pay component outlined in the Policy on Remuneration for Executive Directors.

**The taxable benefits above are in relation to lease car benefits.

Name and title	2020/21						2019/20					
	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total	Salary and fees	Taxable benefits	Annual performance -related bonuses	Long-term performance -related bonuses	All pension -related benefits	Total
	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000	(bands of £5,000) £000	(to the nearest £100) £	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £2,500) £000	(bands of £5,000) £000
John Goulston, Chairman	45–50					45–50	45–50					45–50
Richard Field, Vice Chairman (to 30/04/19, Interim Chairman from 25/05/18 to 31/10/18)							0–5					0–5
Peter Conway, Vice Chairman (from 01/05/19)	15–20					15–20	15–20					15–20
Sola Afuape, Non-executive Director (from 01/12/19)	10–15					10–15	10–15					0–5
Pippa Barber, Non-executive Director	15–20					15–20	15–20					15–20
Paul Butler, Non-executive Director (from 01/03/20)	15–20					15–20	0–5					0–5
Martin Cook, Non-executive Director (from 01/10/18 to 30/09/19)							5–10					5–10
Francis Drobniewski, Non-executive Director (from 01/10/18)	10–15					10–15	10–15					10–15
Steve Howe, Non-executive Director (to 30/04/19)							0–5					0–5
Bridget Skelton, Non-executive Director	15–20					15–20	15–20					15–20
Jennifer Tippin, Non-executive Director (to 01/03/20)							10–15					10–15
Nigel Turner, Non-executive Director (from 01/10/18)	10–15					10–15	10–15					10–15

During the period 1 April 2020 to 31 March 2021, there has been only one change in personnel to the executive team. Lesley Strong left the executive team at the end of July 2020. Lesley retired from the trust in December 2019 and returned in early 2020 on a part-time basis as a programme director to oversee project work. Due to the COVID-19 pandemic Lesley re-joined the executive team in March 2020.

The Remuneration Committee unanimously agreed the chief executive performance had been outstanding and in line with the procedure for performance reviews of executive directors offered a cost of living award. The chief executive declined to accept this and as such his salary remained unchanged.

The trust remunerates Dr Sarah Phillips solely for her management role, as she does not carry out a direct patient care role with the trust.

With reference to the tables above, the value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of the benefit being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

No payments were made for loss of office or to past senior managers in the period.

Pension benefits

Name and title	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31.03.21(bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31.03.21 (bands of £5,000) £000	Cash equivalent transfer value at 01.04.20 £000	Cash equivalent transfer value at 31.03.21 £000	Real increase in cash equivalent transfer value £000	Employer's contribution to stakeholder pension £000
Paul Bentley, Chief Executive Officer	22.5–25	60–62.5	70–75	210–215	1082	1627	498	n/a
Lesley Strong, Chief Operating Officer/Deputy CEO (to 05/12/19), Returned to Executive Team 16/03/20 Returned to Executive Team 16/03/20 to 31/07/20	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Pauline Butterworth, Chief Operating Officer (from 16/12/19)	2.5–5	0	25–30	0	308	367	37	n/a
Gordon Flack, Director of Finance and Deputy CEO (Deputy CEO from 01/12/19)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ali Carruth, Chief Nurse (to 05/01/20), Director of Quality Improvement and Patient Experience (from 06/01/20)	0	0	30–35	55–60	685	507	0	n/a
Mercia Spare, Interim Chief Nurse (from 26/11/18 to 31/12/19), Chief Nurse (from 01/01/20)	2.5–5	10–12.5	40–45	105–110	783	920	106	n/a
Sarah Phillips, Medical Director	2.5–5	0	25–30	25–30	345	385	11	n/a
Natalie Davies, Director of Corporate Services	0–2.5	0	30–35	65–30	509	544	12	n/a
Louise Norris, Director of Workforce, OD and Communications	2.5–5	0–2.5	55–60	145–150	1154	1243	52	n/a
Gerard Sammon, Director of Strategy and Partnerships	7.5–10	15–17.5	50–55	110–115	755	924	149	n/a

Any data expressed as n/a in the above tables is not applicable.

Lesley Strong and Gordon Flack opted out of the NHS Pension Scheme in October 2018. Gerard Sammon opted out of the NHS Pension scheme in July 2020.

As non-executive members do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive members.

Cash equivalent transfer values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETV figures are only applicable up to the Normal Pension Age (NPA). NPA is age 60 in the 1995 Section, age 65 in the 2008 Section, or State Pension Age (SPA) or age 65, whichever is the later in the 2015 scheme.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Inflation figure applied to calculate real increases to pensions, lump sums and CETVs during the period

The inflation applied to the accrued pension, lump sum and CETV is the percentage (if any) by which the Consumer Prices Index (CPI) for the September before the start of the tax year is higher than it was for the previous September. The Consumer Price Index up to September 2019 was 1.7 per cent, therefore for calculation purposes the trust has used an inflation rate assumption of 1.7 per cent to calculate real increases to pensions, lump sums and CETVs over the period. This is in line with the latest Greenbury Pension Guidance.

Fair pay multiple

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Kent Community Health NHS Foundation Trust in the financial year 2020-21 was £205k–£210k (2019-20, £185k–£190k). This was 7.6 times (2019-20, 7.0 times) the median remuneration of the workforce, which was £27k (2019-20, £27k).

In 2020/21, no employee (2019/20, no employee) received remuneration in excess of the highest-paid director. Remuneration ranged from £18k to £209k (2019/20 £11k–£189k).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The slight increase in the fair pay multiple is as a result of the change to the remuneration of the most highly paid director. Though it should be noted this change is temporary as it was not an adjustment to their base pay, but as a result of sale of annual leave entitlement in the year.

Signed.....

Paul Bentley, Chief Executive Officer
(On behalf of the Board)

Date: 17 June 2021

Staff report

This was certainly been an unprecedented year for everyone due to the COVID-19 pandemic. Our people have been truly amazing and continued to deliver outstanding care to our patients during the most difficult of times and we are proud of what was achieved.

This year has also saw us develop our new People Strategy for 2020/2021 to 2023/2024. This was been developed in partnership with our people and reflects the NHS People Plan.

We continued to expand our Nursing Academy and now have a total of 91 apprentices in our academy, comprising registered nurse apprentices, nursing associate apprentices, occupational therapist apprentices and learning disability nurse apprentices. We are truly growing our own workforce of the future for the organisation.

Key achievements in 2020/2021

- We achieved our best ever staff survey results, reaching second place in our benchmark category of community trusts.
- We achieved a reduction in vacancy rate from 6.92 per cent in February 2020 to 4.29 per cent in February 2021.
- We achieved a reduction in turnover from 15.52 per cent in February 2020 to 13.90 per cent in February 2021.
- We exceeded our appraisal completion rate target of 85 per cent, achieving 94.6 per cent (as at February 2021).
- We exceeded our statutory and mandatory training target of 85 per cent, achieving 96.3 per cent (as at February 2021).
- We recruited and trained more than 3,500 colleagues to support the Covid vaccination programme.

The information in the following tables is subject to audit

Staff costs

	Permanent £000	Other £000	2020/21 Total £000	2019/20 Total £000
Salaries and wages	138,730	10,958	**149,688**	**135,634**
Social security costs	11,876	865	**12,741**	**11,351**
Apprenticeship levy	715	–	**715**	**645**
Employer's contributions to NHS pensions	25,802	1,092	**26,894**	**24,309**
Pension cost – other	46	2	**48**	**47**
Other post-employment benefits	–	–	–	–
Other employment benefits	–	–	–	–
Termination benefits	91	–	**91**	**171**
Temporary staff	–	6,913	**6,913**	**6,571**
Total gross staff costs	**177,260**	**19,830**	**197,090**	**178,728**
Recoveries in respect of seconded staff	–	(9)	**(9)**	(299)
Total staff costs	**177,260**	**19,821**	**197,081**	**178,429**
Of which Costs capitalised as part of assets	1,108	271	**1,379**	902

Total staff costs on the COVID-19 response during 2020/21 were £6.4 million, of which £2.4m related to the COVID-19 vaccination programme.

Staff numbers

Average number of employees (WTE basis)

	Permanent number	Other number	2020/21 Total number	2019/20 Total number
Medical and dental	78	7	**85**	85
Ambulance staff	**–**	**–**	**–**	–
Administration and estates	1,440	93	**1,533**	1,449
Healthcare assistants and other support staff	917	148	**1,065**	970
Nursing, midwifery and health visiting staff	1,119	131	**1,250**	1,186
Nursing, midwifery and health visiting learners	25	-	**25**	11
Scientific, therapeutic and technical staff	730	21	**751**	719
Total average numbers	**4,309**	**400**	**4,709**	**4,418**
Of which Number of employees (WTE) engaged on capital projects	28	3	**31**	19

Total average number of employees on the COVID-19 response during 2020/21 were 253 WTE, of which 190 WTE related to the COVID-19 vaccination programme.

Gender distribution

The gender distribution of our workforce as at 31 March 2021 is:

Role	Female (FTE)	Female (%)	Male (FTE)	Male (%)	Total (FTE)	% Total
Director	5.6	65.1	3.0	34.9	8.6	100.0
Other senior managers	19.3	79.4	5.0	20.6	24.3	100.0
Other employees	3,777.4	88.0	517.2	12.0	4,294.6	100.0
Grand total	**3,802.3**	**87.9**	**525.2**	**12.1**	**4,327.5**	**100.0**

Staff sickness absence

Staff absence data can be found at
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates.

Staff policies and actions

Equality and diversity

This year has saw the recruitment of a workforce equality, diversity and inclusion lead to accelerate our progress in this area and deliver on the equality and diversity strategic intent approved by the Board.

As an inclusive employer, the trust is committed to making sure equality of access to employment, career development and training and the application of human rights for all staff.

This approach is set out in the trust's Equality and Diversity Policy, which gives full and fair consideration to disabled applicants and continuing support to staff who become disabled.

Our Workforce Equality Group developed guidance for managers and staff on implementing reasonable adjustments and unconscious bias training was rolled out across the organisation.

Equality is written into the trust's values framework. It makes sure all staff receive training in the subject, it uses equality analysis, and equality and diversity is embedded into trust policies.

Additionally, we use Equality Diversity System Two to record and evidence work we do and publish equality objectives annually on our website. Staff networks promote and support staff from a BAME background, as well as LGBTQ+ disabled staff and those who have religious beliefs.

We are also working closely with Kent Supported Employment Agency to actively recruited disabled people. We were thrilled to be finalists in the Recruitment Industry Disability Initiative (RIDI) awards for our work in this area.

We are proud to have been awarded Disability Confident Level Two and will continue to work with our partners and people to make sure we maximise every opportunity to build the best and most diverse workforce possible.

Gender pay gap

Due to the COVID-19 pandemic, there was an extension to when our gender pay gap information for 2020/21 needs to be submitted. Therefore, the latest data available is for 2019/20 submission which is based on a snapshot as at 31 March 2019.

Information about our gender pay gap is available on our website: https://www.kentcht.nhs.uk/download/gender-pay-gap-report-2019/ or via https://gender-pay-gap.service.gov.uk.

Freedom to speak up

The trust had a freedom to speak up guardian (FTSU) in post all year – this person has a key role in fostering a culture of openness.

A campaign to promote the benefits of speaking up ran throughout the year and will continue during 2021/22. The campaign sought to raise awareness of speaking up and included ways to get in touch, such as the dedicated email and phone line for colleagues to report their concerns.

Between 1 April 2020 and 31 March 2021, the FTSU guardian logged and was involved in 24 new cases. Themes of the cases were discussed with the chief executive and a six-monthly report was presented to the Strategic Workforce Committee. The trust has a named non-executive director lead for freedom to speak up, who acts as an alternative source of advice and support for the guardian. Sola Afuape is the non-executive director lead.

The trust also has a number of freedom to speak up ambassadors and their role includes encouraging colleagues to speak up by providing informal advice, sign-posting and promoting positive examples of changes that have occurred as a result of speaking up.

The FTSU index is calculated as the mean average of responses to the following four questions from the 2020 NHS Staff Survey:

- per cent of staff "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 16a)
- per cent of staff "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 16b)
- per cent of staff "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 17a)
- per cent of staff "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 17b).

The national average of the index was 79.2 per cent and community trusts averaging 84.6 per cent in 2020. KCHFT scored 87.0 per cent the second highest ranking trust in the country compared to the best of 87.6 per cent.

Consultation with staff

The trust takes a consultative approach to engagement with staff. Our active staff partnership forum is well attended by both Staffside and management representatives. All change proposals are taken to this forum for discussion, as well as full staff consultation regarding any changes that will impact staff. Views from all parties are gathered and given due consideration before any final decisions are made.

Involvement of staff in trust performance

The trust has a robust performance reporting structure from the Board down with a clear line of accountability and monitoring. The Integrated Performance Report is supported by division level performance reports that are produced monthly and reviewed and discussed at performance reviews with the Executive Team. These division reports also include service level dashboards and in some cases include performance data for individual teams to allow services to have a clear understanding of their performance. Service leads are encouraged to share these reports within their teams to give staff an understanding of their role in performance and share accountability.

In addition, the trust has a business intelligence tool which gives team leaders and managers the ability to access performance data on a more routine basis and share this information with their teams, or investigate areas of adverse performance.

A regular snapshot of organisational performance on key metrics is shared with all teams via the Team Brief newsletter, which is prepared by our Communications Team. During the COVID-19 pandemic we also produced a weekly infographic with key information – such as levels of PPE in stock, which was shared directly with all staff.

Health and safety performance

The trust fully meets all its obligations under the Health and Safety at Work etc. Act 1974 and various associated regulations. The trust has a Health and Safety Committee, which reports to the Corporate Assurance and Risk Management Group. Health and safety, fire, security, estates and moving and handling report into the Health and Safety Committee to provide assurance of compliance with safety legislation.

For 2020/21, the trust reported 15 incidents, which fell under the requirements of the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). All reports were submitted to the Health and Safety Executive within the required legal timeframes.

The trust's approach to health and safety is documented in the health and safety policy and other associated policies, strategies and guidance available on the staff intranet.

Occupational health and counselling

Optima is our occupational health provider. It provides pre-employment screening, vaccinations, advice to managers following referral to support our staff, as well as numerous online resources available to both staff and managers to help them with their health and wellbeing needs.

Our staff counselling provision is provided by Staff Care Services and can be accessed by colleagues directly or via a management referral. The service is entirely confidential. The initial four sessions are funded by the trust with the option to extend this provision if necessary with the agreement of the line manager.

Counter fraud and corruption

The trust's counter fraud specialists provide professional expertise and operate within a national legal framework for tackling fraud, corruption and bribery. All work was completed in accordance with legal standards and in compliance with guidance from NHS Counter Fraud Authority. The trust's approach to counter fraud and corruption is documented in its Counter Fraud, Corruption and Bribery Policy, available to staff on the intranet.

Staff survey

Staff engagement

A detailed action plan was compiled in response to the 2019 staff survey results, however, due to the pandemic, business continuity commenced.

Looking back at that action plan, we achieved many of the actions due to our response to the pandemic. The table below shows what our actions were and how we addressed these through the pandemic.

Action	Pandemic response
Run communication campaigns to engage with staff	Daily covid updates to all staff, PPE infographics, video messages from Executive Team colleagues, Schwartz Rounds, and Big Listen 2 engagement campaign to inform our new people strategy.
Making staff feel valued	Increased communication from senior leadership team, wobble rooms created, redeployment of resources organisationally to support frontline colleagues, constant messaging of what a phenomenal job everyone was doing during unprecedented times. Letters of appreciation to staff.
Promotion of flexible working	Many of our colleagues worked remotely from home during the pandemic. Managers were encouraged to consider whether or not permanent working from home options could be made available for their team members. In support of this, a permanent home working toolkit was developed.

We have also made sure our people have been well supported throughout the pandemic with access to multiple resources should they need them. These include:

- a dedicated section on our staff intranet called 'You' which sets out a range of wellbeing interventions for our staff to access. This includes videos on relaxation, breathing exercises, how to stay fit, our counselling service and Time to Change mental health champions, a dedicated health and care staff support service including confidential support via phone and text message
- specialist bereavement support
- free access to mental health and wellbeing apps
- guidance for key workers on how to have difficult conversations with their children
- group and one-to-one support, including specialist services to support our black, Asian and minority ethnic (BAME) colleagues
- mental health resources and support
- webinars providing a forum for support and conversation with experts
- coaching and mentoring support
- online resources, toolkits and guidance on topics such as maintaining team and individual resilience; managing stress and maintaining routines; compassionate leadership in a crisis; and creating pause spaces to support teams working under pressure, REACT mental health conversation training for managers to enable them to support staff through compassionate, caring conversations about mental health and emotional wellbeing.
- wobble rooms at each main site
- virtual wobble rooms for colleagues working remotely
- time to talk rooms
- extended counselling service
- Schwartz Rounds
- guidance on domestic abuse, debt management (including access to grants), managing media anxiety
- physical wellbeing tips on working from home
- deals and discounts
- promotion of the Kent Together helpline
- regular thanks from senior colleagues including direct communications from the chief executive and chair

We also developed our new People Strategy this year, covering 2021 to 2024, which our workforce contributed to formulating through our Big Listen 2 event. A key part of our People Strategy has been our culture change programme and this will be a continued focus. We are developing a culture of trust and ownership, where people feel engaged and empowered to make decisions and act upon them.

NHS staff survey

The NHS staff survey is carried out annually. From 2019 onwards, the results from questions are grouped to give scores in 11 key themes. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The NHS staff survey is conducted annually. From 2019 onwards, the results from questions are grouped to give scores in 11 key themes. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2020 survey among trust staff was 62.4 per cent (2019: 58.8 per cent), the highest the organisation has ever achieved. Scores for each indicator together with that of the survey benchmarking group (other community trusts) for the past three years are presented below. Please note that the comparison figure for benchmarking is the average score of our comparator organisation (with best and worse scores shown in brackets).

	2020/21		2019/20		2018/19	
	KCHFT	Benchmarking Group – other community Trusts*	KCHFT	Benchmarking Group – other community Trusts*	KCHFT	Benchmarking Group – other community Trusts*
Equality, diversity and inclusion	9.5	9.4 (best 9.5/worst 8.8)	9.5	9.4 (best 9.6/worst 8.8)	9.5	9.3 (best 9.6/worst 8.8)
Health and wellbeing	6.7	6.3 (best 6.7/worst 6.0)	6.4	6.0 (best 6.7/worst 5.4)	6.2	5.9 (best 6.5/worst 5.2)
Immediate managers	7.6	7.2 (best 7.6/worst 7.0)	7.6	7.2 (best 7.6/worst 6.9)	7.4	7.0 (best 7.6/worst 6.7)
Morale	6.7	6.5 (best 6.7/worst 6.1)	6.6	6.3 (best 6.7/worst 5.9)	6.2	6.1 (best 6.6/worst 5.7)
Quality of care	7.6	7.5 (best 7.9/worst 7.1)	7.6	7.4 (best 8.0/worst 7.1)	7.3	7.3 (best 8.0/worst 7.1)
Safe environment – bullying and harassment	8.8	8.5 (best 8.9/worst 8.0)	8.6	8.4 (best 8.7/worst 7.6)	8.6	8.4 (best 8.8/worst 7.1)
Safe environment – violence	9.8	9.7 (best 9.9/worst 9.6)	9.8	9.7 (best 9.9/worst 9.6)	9.8	9.7 (best 9.9/worst 9.6)
Safety culture	7.5	7.1 (best 7.5/worst 6.7)	7.3	7.0 (best 7.5/worst 6.5)	7.0	7.0 (best 7.3/worst 6.2)
Staff engagement	7.4	7.3 (best 7.5/worst 6.9)	7.4	7.2 (best 7.5/worst 6.6)	7.0	7.1 (best 7.5/worst 6.5)
Team working	7.4	6.9 (best 7.5/worst 6.6)	7.5	7.1 (best 7.5/worst 6.5)	7.2	6.9 (best 7.4/worst 6.5)

Key data highlights

- KCHFT had better results than 2019/20 in four themes, all of which were statistically significant improvements.
- There were no themes which received a statistically significant lower score than 2019/2020. KCHFT maintained or improved across all themes.
- KCHFT is the best performing community trusts in five themes.
- KCHFT had the highest response rate that the organisation has ever achieved.
- KCHFT came second in the benchmarking group overall.

Future priorities and targets

Our approach will be to develop action plans, both corporate and directorate level, to address the areas of the survey with the biggest variance from our community trust comparators. We believe we can push ourselves to achieve the "best" within our benchmarking group.

Our main overall corporate focus will continue to be:

- reducing discrimination felt by colleagues via the equality and diversity strategy and action plan
- further developments on health and wellbeing including MSK
- re-energising Quality Improvement
- quality of care
- reimagine team working.
- staff engagement as this underpins all themes

The Strategic Workforce Committee will monitor progress against action plans. Quarterly, we will measure whether or not actions are having an impact via the staff friends and family test.

Overall, the staff survey findings for 2020 are very positive. It is important we continue to strive to improve all scores; that there is ownership of actions and these are followed through so every member of staff understands what they have to say does matter and that as a trust we listen and act on feedback.

Summary of local surveys

- Engagement with our 5,000-strong workforce needs to happen all-year round.
- The NHS staff survey is an excellent way of measuring how colleagues feel, but we know that more needs to be done to make sure the trust is having a consistent two-way conversation with our workforce.
- In 2020/21, we held Big Listen 2 during the summer. This was first held two years ago. Originally, it was designed to find out if people were happy working at KCHFT or if they intended to leave the organisation at some point. Feedback from it helped shape priorities for the organisation.
- Last summer's Big Listen 2 asked exactly the same questions as before, but also focussed on the trust's Covid response and our revised People Strategy.
- In all, 1,153 colleagues took part and the feedback was overwhelmingly positive and constructive; it again is helping shape work within KCHFT. As part of Big Listen 2, 15 virtual one-hour information follow-up sessions were held with 88 people attending.
- Any colleagues who were temporarily moved to support the effort against COVID-19 were asked to take part in a survey rating and feeding back on their experience.
- We also use regular polls on our intranet flo to temperature check how colleagues are feeling and asking for input, for example around organisational priorities.
- We also carry out regular surveys to our workforce, including one around what our quality priorities should be, for example.
- In February 2020, a communications and engagement survey was carried out asking colleagues about preferred channels of communication, specific projects (to provide benchmark data) and ambitions for the future.
- The national staff friends and family test was suspended in 2020/21 as a result of the pandemic.

Trade union facility time disclosures

Table 1

Relevant union officials

Number of employees who were relevant union officials during the relevant period	FTE employee numbers
12	11.11

Table 2

Percentage of time spent on facility time

Percentage of time	Number of employees
0	4
1 – 50	8
51 – 99	0
100	0

Table 3

Percentage of pay bill spent on facility time

Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

	Figures
Provide the total cost of facility time	£13,489
Provide the total pay bill	£187,732,193
Provide the percentage of the total pay bill spent on facility time	0.0072%

Table 4

Paid trade union activities

As a percentage of the total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

Time spent on paid trade union activities as a percentage of total paid facility time hours
32 per cent

*best and worse scores in brackets

Expenditure on consultancy

The trust's own expenditure on consultancy in 2020/21 was £637k (2019/20 £1,457k). The trust hosted the Kent and Medway Sustainability and Transformation Partnership until 30 September 2020, which incurred consultancy expenditure of £1,242k (2019/20 £2,483k) during the reporting period.

Highly-paid off-payroll worker engagements as at 31 March 2021 earning £245 per day or greater	Number of engagements
Number of existing engagements as of 31 March 2021	0
Of which…	
Number that have existed for less than one year at time of reporting.	0
Number that have existed for between one and two years at time of reporting.	0
Number that have existed for between two and three years at time of reporting.	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2021 earning £245 per day or greater	Number of engagements
Number of off-payroll workers engaged during the year ended 31 March 2021	0
Of which…	
Not subject to off-payroll legislation*	0
Subject to off-payroll legislation and determined as in-scope of IR35*	0
Subject to off-payroll legislation and determined as out-of-scope of IR35*	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which: number of engagements that saw a change to IR35 status following review	0

*A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the trust must carry out an assessment to determine whether or not that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021	Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	18

Exit packages

The information in the following tables is subject to audit

Reporting of compensation schemes – exit packages 2020/21

	Number of compulsory redundancies number	Number of other departures agreed number	Total number of exit packages number
Exit package cost band (including any special payment element)			
<£10,000	2	20	**22**
£10,001-£25,000	–	–	–
£25,001-50,000	2	–	**2**
£50,001-£100,000	–	–	–
£100,001-£150,000	–	–	–
£150,001-£200,000	–	–	–
>£200,000	–	–	–
Total number of exit packages by type	**4**	**20**	**24**
Total resource cost (£)	£91,000	£59,000	**£150,000**

Reporting of compensation schemes – exit packages 2019/20

	Number of compulsory redundancies number	Number of other departures agreed number	Total number of exit packages number
Exit package cost band (including any special payment element)			
<£10,000	6	13	**19**
£10,001-£25,000	5	1	**6**
£25,001-50,000	1	–	**1**
£50,001-£100,000	–	–	–
£100,001-£150,000	–	–	–
£150,001-£200,000	–	–	–
>£200,000	–	–	–
Total number of exit packages by type	**12**	**14**	**26**
Total resource cost (£)	£171,000	£55,000	**£226,000**

Exit packages: other (non-compulsory) departure payments

	2020/21		2019/20	
	Payments agreed number	Total value of agreements number	Payments agreed number	Total value of agreements number
Exit packages: other (non-compulsory) departure payments				
Voluntary redundancies including early retirement contractual costs	–	–	–	–
Mutually agreed resignations (MARS) contractual costs	–	–	–	–
Early retirements in the efficiency of the service contractual costs	–	–	–	–
Contractual payments in lieu of notice	20	59	14	55
Exit payments following employment tribunals or court orders	–	–	–	–
Non-contractual payments requiring HMT approval	–	–	–	–
Total			**14**	**55**
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	–	–	–	–

Disclosures set out in the NHS foundation trust code of governance

NHS foundation trust code of governance

Kent Community Health NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

This table of disclosures is required so the trust complies with the requirements of the code of governance.

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Board and Council of Governors	A.1.1	The trust's Board meets nine times a year; four of those meetings are held in public. During the COVID-19 pandemic, the public are unable to attend and the meetings are broadcast virtually. Five meetings are held to discuss trust strategy and board development. There are approved standing orders, standing financial instructions and a scheme of delegation in place. The annual governance statement describes the role of each of the Board's committees. The trust's constitution sets out how disagreements between the council and the Board would be resolved; the chair, as chair of both bodies, would initially seek to resolve the disagreement, if this is not successful, a joint committee of governors and directors would be established. If this committee's recommendations were unable to resolve the dispute, the Board would make a final decision. A referral to NHS England and NHS Improvement or other external body might also be considered. There has been no requirement to activate this process during 2020/21.
Board, Nomination Committee(s), Audit and Risk Committee, Remuneration and Terms of Service Committee	A.1.2.	This annual report describes the roles and responsibilities of the Board on pages 27 to 32. The number of Board, Council and committee meetings and a record of attendance are found on page 33.
Council of Governors	A.5.3	Page 35 of this annual report identifies the members of the Council of Governors, the lead governor and their respective constituencies. The council has formally met three times during 20120/21. It is due to continue formal quarterly meetings. The April 2020 meeting was cancelled due to COVID-19.
Board	B.1.1	The directors of the trust all meet the required independence criteria set out by NHS England and NHS Improvement. The directors are identified on pages 25 to 32 of this annual report. All material pecuniary and non-pecuniary interests are declared and reported as per the trust's policy and regularly reported to the Board. They are also included in this annual report and are published on the Trust's public website.
Board	B.1.4	The biographies of Board members are included in this report on pages 27 to 32. The Board has completed a self-assessment and considers that the skills and experience of the members gives an appropriate balance in order to effectively conduct its business. This is reviewed continually through the Nominations Committee.

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Board Council of Governors	B.2.2	Directors on the Board and governors on the Council of Governors meet the fit and proper persons test as described in the provider licence. The trust also abides by the updated guidance from the Care Quality Commission (CQC) regarding appointments to senior positions in the organisation subject to CQC regulations.
Nominations Committee(s)	B.2.10	The Nominations Committee is a committee of the council, which is designed to consider the appointment or removal, succession planning and process for appraisal for non-executive directors. The committee does this by reviewing the overall balance and skills of all the non-executive directors and makes recommendations to the council for consideration. The Nominations Committee met twice in the past year. The April Nominations Committee was cancelled due to COVID-19.
Chair/ Council of Governors	B.3.1.	The job specification for the trust's chair defines the role and capabilities required and the expected time commitment. The Nominations Committee will oversee future appointments, as required.
Council of Governors	B.5.6	Mechanisms for canvassing members continue to develop. Election of governors – there is a process for electing new governors, which is conducted by an external election company (formerly Election Reform Services). In the past 12 months, seven public governors were elected. The council now consists of 13 publicly elected governors, five staff elected governors and four appointed governors. All governors have been to at least one formal meeting of the council during the past 12 months.
Board	B.6.1	The Board is assessed for effectiveness and individual effectiveness assessments of Board members are conducted as part of the appraisal process. The Board collectively assesses its effectiveness after every formal meeting.
Board	B6.2	The Audit and Risk Committee takes responsibility for oversight of the governance process. It achieves this through internal audit, external audit, deep dives and the assessment of the risk profile of the organisation.
Board	C.1.1	The statement of the directors' responsibilities for the annual report and accounts is on page 27.
Board	C.2.1	This is covered in the annual governance statement included in this annual report.
Audit Committee/ Control Environment	C.2.2	This is covered in the annual governance statement included in this annual report. The independent auditor's report is on page 78.

Disclosure relating to	NHS Improvement Code of Governance reference	Kent Community Health NHS Foundation Trust disclosure
Audit Committee/ Council of Governors	C.3.5	This information is included in the trust's annual governance statement, included in this report.
Audit Committee	C.3.9	This information is included in the trust's annual governance statement, included in this report.
Board/Remuneration Committee	D.1.3	None of the trust's executive directors are released to serve on external appointments, such as non-executive directorships elsewhere.
Board	E.1.5	The members of the Board and, in particular the non-executive directors, will attend meetings of the Council of Governors, as and when required, to develop an understanding of the views of the council and the trust's members about the organisation. The Board will take account of surveys and consultations canvassing the opinion of the membership.
Board/Membership	E.1.6	There is a trust membership strategy. The methodology for NHS monitoring of effective member engagement and how representative it is of the community the trust serves is included in the communications and engagement strategy. The council has established a Communications and Engagement Committee to discharge this responsibility.
Membership	E.1.4	The trust's corporate services director oversees compliance with this requirement. The governors of the trust can be contacted by: email: kcht.governors@nhs.net phone 07468 700220 Post: Governor Support Office Kent Community Health NHS Foundation Trust The Oast Unit D Hermitage Court Hermitage Lane Barming Maidstone Kent ME16 9NT

Statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of Kent Community Health NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given accounts directions that require Kent Community Health NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Kent Community Health NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the accounting officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the accounts direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- make sure the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation Trust's performance, business model and strategy
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to make sure the accounts comply with requirements outlined in the above mentioned act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed.....

Paul Bentley, Chief Executive Officer

Date: 17 June 2021

Annual governance statement

Annual Governance Statement

1 April 2020 to 31 March 2021
Kent Community Health NHS Foundation Trust
(Organisational Code – RYY)

1. Scope of responsibility

As accounting officer, I have responsibility for maintaining a robust system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, while safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for making sure the NHS foundation trust is administered prudently and economically and resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

In the delivery of my responsibilities and objectives, I am accountable to the Board and my performance is reviewed regularly and formally by the chair on behalf of the Board.

During 2020/21, the organisation routinely reported on financial, operational, and strategic matters.

2. The purpose of the system of internal control

The system of internal control is based on a continuing programme designed to recognise, identify and prioritise the trust's risks against the achievement of aims, objectives and compliance of trust policies. The aim of the internal control systems is to alleviate the likelihood of risks occurring and to manage them effectively and efficiently.

The system of internal control has been in place in Kent Community Health NHS Foundation Trust for the year end 31 March 2021 and up to the date of approval of the annual reports and accounts.

3. Capacity to handle risk

The Governance Framework of Kent Community Health NHS Foundation Trust is overseen by the trust Board, which comprises of executive and non-executive directors.

The Board's function is to:

- make sure all stakeholders have a good understanding of Kent Community Health NHS Foundation Trust's purpose
- set the values for the trust and its strategic direction
- hold management to account for the success and safety of the trust, including risk management
- shape the organisational culture that supports its vision and values and encourages openness, honesty and integrity.

Through its strategic vision, values and goals, the Board is committed to delivering a strong, financially viable and sustainable organisation with quality of service at the heart of its business.

In March 2015, the trust was authorised as a foundation trust and continues to assess itself to meet all of the requirements of the NHS Code of Governance. The Board and Audit and Risk Committee receive regular reports of the key risks received from the organisation and regularly review the Board Assurance Framework which contains the trust's strategic risks.

The trust's approach to risk management is proactive. Leadership and co-ordination of risk management activities is provided by the director of corporate services and their team with support from all members of the Executive Team. During 2020/21, Kent Community Health's trust risk appetite has been tested in full in response to the COVID-19 pandemic.

Operational responsibility rests with all staff aligned to their individual roles. Risk management training is part of staff induction and training updates for existing staff are also provided.

Risk identification, prioritisation, mitigation or elimination occurs through assessment and grading using a nationally recognised matrix of impact and likelihood. Incident reporting is a factor in the continuing assessment of risk and results in the instigation of changes in practice. Complaints and other feedback from users and stakeholders are also used and reported to the Board.

Identifying sources of potential risk and proactively assessing risk situations forms part of everyday working practice throughout the trust, this includes:

- identifying potential risk issues through incidents, near misses and complaints through the triangulation of data
- investigating and analysing root cause analysis
- discussing risk and incident management through local governance agendas
- risk management is incorporated in objective setting and appraisals
- Risk Team ownership of monitoring the delivery and effectiveness of actions taken to control risk
- learning from near misses, risk events, legal claims and complaints and sharing the lessons learned across the trust.

Through its strategic vision, values and goals, the Board is committed to delivering a strong, financially viable and sustainable organisation with quality of service at the heart of its business. Given the changing landscape initiated by the COVID-19 pandemic and its impact on the system, the trust has taken this as an opportunity to review risk appetite to support key decision-making moving forward.

To give Board members grounding and greater understanding and clarity, there has been development in engaging each member with service reviews, to help understand patient journeys and pathways with case interrogation of individual case studies. In addition, the Board is invited to senior managers' conferences, team leaders' conferences and executive and heads of service events, where they meet senior management and discuss new service models, service improvements and innovations.

4. Risk Management Controls Framework

As accountable officer, I have overall responsibility for risk management. Specific responsibilities are delegated to senior managers throughout the organisation. The Board oversees risks, establishes a risk appetite for high level risks on a risk-by-risk basis and encourages proactive identification and mitigation of risks.

The Risk Management Policy was presented to the Audit and Risk Committee in 2020. The policy describes the trust's risk appetite and the approach to managing and tolerating risks. The effective implementation of the strategy enables the delivery of a quality service and, alongside staff training and support, provides an improved awareness of the measures needed to prevent, control and contain risk.

The top risks identified through the risk management process that have a significant impact on the ability of the trust to deliver its strategic goals are documented in the Board Assurance Framework.

During 2020/21 there has been a significant amount of work carried out to manage, rationalise and make sure consistency of the risks identified through the risk management process. Key strategic risks (Board Assurance Framework) have been identified through strategic assessment, triangulation and business planning process. These are:

- risk that the significant impact on the system and the organisation due to the COVID-19 pandemic may result in the inability to delivery services to an acceptable standard either in coverage or quality.
- risk that the balance of factors, including safety, operational effectiveness, patient need and engagement, to consider as part of reset may impact our ability to stand up all services
- system and partner plans to reset and restart could be insufficient or insufficiently coordinated to meet the demand resulting in the system being overwhelmed and patients not receiving the services they need
- risk that the organisation's services may be overwhelmed as result of the impact of winter pressures in combination with COVID-19
- risk that the on-going pressure and staff shortages specifically in community hospitals and rapid response services, as a result of growing vacancies, high acuity of patients and staff absence may result in unacceptable demands on staff and impact on safer staffing levels, a poorer service to patients and/or the need to shut services with the resultant impact on the system
- risk that the organisation may encounter collaborative challenges with health partners and demands of an unprecedented logistical scale could result in the trust not being able to cope with the system wide delivery of the COVID-19 vaccination programme
- the pace of integrated care system transition is resulting in an inconsistent narrative, which could impact our ability to progress the strategic aims of the organisation.

Risk management is a core component of job descriptions within the trust. A range of risk management training is provided to members of staff and there are procedures in place which describe roles and responsibilities in relation to the identification, management and control of risk, along with the risk management process of escalation and de-escalation to be followed. All relevant risk policies and procedures are available to colleagues on the intranet.

The trust learns from good practice through a range of mechanisms including clinical supervision, continuing professional development, clinical and process audit and application of evidence-based practice. At the heart of the trust's risk management policy is the desire to learn from events and situations in order to continuously improve quality of care.

Leadership and co-ordination of risk management activities is provided by the corporate services director, assistant director of corporate operations and the Risk Management Team with support from all members of the Executive Team. Risk management training is part of staff induction and training updates for existing colleagues are also provided.

Risk identification, prioritisation, mitigation or elimination occurs through assessment and grading using a nationally-recognised matrix of impact and likelihood. Incident reporting is a factor in the ongoing assessment of risk and results in the instigation of changes in practice. Complaints and other feedback from users and stakeholders are also used and reported to the Board. The trust operates a We Care review programme which encompasses the NHS Improvement's well-led framework. The visits encourage shared learning, provide assurance and stimulate quality improvements. The visits focus on assessing our CARE values in action, as well as assessing compliance with the CQC fundamental standards – safe, effective, caring, responsive and well-led.

4.1 Risk Management during the pandemic

The pandemic has undeniably presented us with the opportunity to look objectively at our processes. Just as the trust has taken this time for a refreshed approach to its strategy and governance, our risk appetite and ambitions are also on the forefront of the 'reset and re-imagine programme'. Namely, the fundamental principles of our risk management strategy going forward will be to:

- continue to deliver and embed the trust's defined risk appetite
- always available approach to one-to-one risk management support for all staff
- embrace change and taking risks to shape the, new normal. Align risk appetite to our new strategic ambitions and clearly set out the process of embedding into operational and front line approach.

5. Care Quality Commission

In 2019, the CQC carried out a full inspection of trust services which concluded an overall 'Outstanding' rating. This makes Kent Community Health NHS Foundation Trust the third community trust in the country to be outstanding overall and one of 23 provider trusts to be outstanding overall in England. We are the only community provider trust in the south east to have this rating.

Individual ratings against each domain were:

- Are services safe? **Good**
- Are services effective? **Outstanding**
- Are services caring? **Outstanding**
- Are services responsive? **Good**
- Are services well-led? **Good**

Findings included:

- engagement with patients, staff and stakeholders seen as business as usual and vital to delivering services
- leaders have an inspiring purpose, striving to deliver and motivate staff to succeed. Staff felt supported, valued and respected by their leaders
- there was significant cultural shift to reduce bureaucracy and a healthy and authentic culture of valuing staff, openness, fairness and putting the patient at the heart of every policy, strategy and service delivered.
- a clear proactive approach to seeking out and embedding new and more sustainable models of care.
- safe use of innovative and pioneering approaches to care and how it is delivered are actively encouraged.
- rigorous and constructive challenge from patients was welcomed.

6. The Governance Framework of the Organisation

6.1 Council of Governors

The Council of Governors represent the interests of our members and the wider public. It has two general duties – to hold the non-executive directors to account for the performance of the Board and to represent the views of the local population.

The governors' role is to enable local people, patients, staff and our partners to have a say about the development of community services. They are a direct link between the trust and the people it serves.

Governors have an important role to play in making the trust publicly accountable for the services it provides. Each category of governor – public, staff and appointed governors – brings valuable perspectives and contributions to the trust's activities and future planning.

The full Council of Governors normally meets quarterly but the April 2020 meeting was cancelled due to COVID-19. Due to the pandemic and government restrictions, a digital annual meeting was presented in September 2020, alongside the trust's annual meeting. This can be viewed at www.kentcht.nhs.uk/annualmeeting

6.2 Trust Board

The trust's Board has overall responsibility for the activity, integrity and strategy of the trust and is held accountable, through its chair, by our Council of Governors, which is made up of members of the public elected to represent the views of residents.

In order to give the Board members grounding and greater understanding and clarity there has been development in engaging each member with we care reviews to help understand the patient journeys and pathways with interrogation of individual case studies. During the pandemic, we care visits took place between September and November with non-executive directors in attendance. Non-executive directors also attended the virtual quality review panels which identified the key lines of enquiry for further exploration during the on-site visit.

The Board is also invited to the senior manager conferences, executive and heads of service conferences where they meet the senior management and discuss new service models, service improvements and innovations. These events took place virtually during the pandemic.

The Board has the following key functions:

- to set strategic direction, define trust objectives and agree trust operating plans
- to monitor performance and ensure corrective action is taken, where required
- to make sure financial stewardship is met
- to make sure high standards of corporate and clinical governance are met
- to appoint, appraise and remunerate directors
- to encourage dialogue with external stakeholders.

The board is made up of non-executive directors who use the skills and experience gained from the private, public and voluntary sectors to help run the trust, but who do not have day-to-day managerial responsibilities within the trust and executive directors who are paid employees with clear areas of work responsibility within the trust.

To support the whole organisation's focus on the pandemic, governance processes were assessed and revised to align to the response while still ensuring the core assurance required. This was supported by daily or real time information and assurance reporting on key areas of performance including incidents, activity and patient feedback.

As part of the response to the COVID-19 pandemic, the trust enhanced the governance processes with the implementation of daily incident command and control meetings that reported through to the Executive Team.

6.3 Committees of the trust's Board

The trust is supported by committees whose membership includes non-executive directors, directors and senior managers of the organisation. A formal update report for each committee is reported to the Board, regularly outlining the activity carried out against the individual committee's terms of reference. During the pandemic, the committees continued to meet virtually. The committees are:

6.2.1 Audit and Risk Committee

This committee is a non-executive committee of the Board with delegated decision-making powers to provide assurance and hold the Executive Team to account for the corporate governance and internal control.

The director of finance, director of corporate services, head of internal audit, head of external audit and the local counter fraud specialist attend meetings. Other individuals with specialist knowledge attend for specific items with the consent of the chair.

The Audit and Risk Committee provides the board with assurance on key aspects including:

- effective systems of internal control and risk management.
- effective internal audits and service reviews
- reviewing the findings of external audits and other significant assurance functions
- reviewing risks which have been assigned to the committee and providing assurance that key controls and action plans are adequate to address gaps in controls

- reviewing and reporting on the annual report and financial statements.

It is incumbent upon the Audit and Risk Committee to work closely with other committees of the trust's Board to make sure all issues relating to finance, risk management and internal control are considered in a holistic and integrated way throughout the system.

6.2.2 Charitable Funds Committee

This committee acts on behalf of the corporate trustee, in accordance with the Kent Community Health NHS Foundation Trust's standing orders to oversee the charity's operation and to make sure the administration of charitable funds is distinct from the trust's exchequer funds.

The committee is authorised by the Board to obtain reasonable external, legal or other independent professional advice, and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

The Charitable Funds Committee oversees all aspects relating to charitable funds within Kent Community Health NHS Foundation Trust. The committee's main functions include:

- supporting and monitoring fundraising on behalf of the trust's charity
- developing and approving charitable funds guidelines and policies
- considering and managing charitable funds, applications and investments
- reviewing risks which have been assigned to the committee and providing assurance that key controls and action plans are adequate to address gaps in controls

6.2.4 Finance Business and Investment Committee

This is a committee of the Board and maintains robust financial management by monitoring financial performance and making recommendations to the executive team and the Board. Executive directors and senior service leads attend by invitation when the committee discusses issues relating to their area of responsibility. The committee's main functions include:

- receiving and approving financial strategy and policy documents
- monitoring the financial management of income and expenditure
- approving and monitoring the financial management of the balance
- approving and assessing commercial management issues
- scrutinising current financial performance and future financial plans
- monitoring performance against cost improvement plans
- scrutinising the development and implementation of service line reporting and service line management
- monitoring decisions to bid for business opportunities and approve those up to £15 million contract turnover in line with trust strategy and reviewing and then referring and recommending larger and novel bids to the Board for approval
- reviewing and approving capital investment decisions between £1million to £3 million within capital budget and the overall capital programme development, referring with recommendation, larger cases to the Board for approval
- reviewing and approving revenue business cases between £1million to £3 million annual values and referring with recommendation, larger cases to the Board or approval
- approving Treasury Management Policy and scrutinising implementation
- reviewing risks which have been assigned to the committee and providing assurance that key controls and action plans are adequate to address gaps in controls.

6.2.5 Quality Committee

This is a committee of the Board with delegated decision-making powers. The chief nurse, the medical director, chief operating officer and the director of participation, experience and patient engagement are members. Other individuals with specialist knowledge attend for specific items with the consent of the chair. The committee invites clinical representatives to attend its meetings to provide assurance on key governance and risk issues and quality improvement.

The Quality Committee provides leadership and assurance that clinical governance systems and processes are in place and effective in providing safe, high quality care. The Committee's main functions include:

- providing oversight of performance and risk of the trust strategic objectives/enablers preventing ill health and high quality care as assigned to the committee by the Board
- making sure the strategic priorities for quality assurance are focused on those which best support

delivery of the trust's quality priorities in relation to patient experience, safety of patients and service users and effective outcomes

- reviewing compliance with regulatory standards and statutory requirements, for example those of the Duty of Candour, the Care Quality Commission, NHS Resolution and the NHS Performance Framework
- overseeing we care visits associated action plans and risks
- reviewing quality risks which have been assigned to the Quality Committee and providing assurance that key controls and action plans are adequate to address gaps in controls
- eviewing the annual quality report ahead of its submission to the Board for approval
- overseeing deep dive reviews of identified risks to quality identified by the Board or the committee, particularly serious incidents and how well any recommended actions have been implemented
- reviewing how lessons are disseminated, learned from and embedded in the trust from 'ward to Board'
- Overseeing the ratification of clinical policies and any other formal clinical document where mandatory compliance is required.

The trust's approach to quality is informed by listening to patient experience and understanding safety alongside delivering and maintaining services. This approach has been formally identified through trust values and strategic objectives with executive leadership and Board ownership.

6.2.6 Remuneration and Terms of Service Committee

Committee members are non-executive directors. The committee is chaired by the trust's chair. The chief executive and director of workforce, organisational development and communications will also normally attend meetings, except where matters relating to them are under discussion.

The committee is responsible for setting the remuneration and conditions of service for the chief executive and other directors with Board responsibility who report directly to the chief executive and other directors; making sure these properly support the objectives of the trust, represent value for money and comply with statutory requirements.

The committee does not determine the remuneration of the non-executive chair and the non-executive directors, which is set by the Council of Governors.

When required, the committee will oversee the appointment of executive directors in accordance with standing orders. During these sittings, the committee will be known as the executive appointments committee and the minutes reflect this position.

6.2.7 Strategic Workforce Committee

This is an assurance committee that has delegated authority from the Board to provide assurance and hold the executive team to account for strategic workforce issues. Its purpose is also to keep abreast of the strategic context in which the trust is operating in, the consequences and implications on the workforce.

The Strategic Workforce Committee provides advice and assurance to the Board on all matters relating to workforce planning, strategy and pay and rewards. It is also responsible for organisational development including health and wellbeing and equality, diversity and inclusion.

The committee's main functions include:

- overseeing the development and implementation of the trust's people strategy, making sure the trust has robust plans in place to support continuing development of the workforce
- reviewing the trust's plans to identify and develop leadership capacity and capability in the trust, including talent management
- making sure there is an effective workforce plan in place, so the trust has sufficient staff with the necessary skills and competencies to meet the needs of patients and service users
- making sure the trust continually reviews its workforce models, to reflect new roles and new ways of working to support delivery of the trust's contractual obligations
- receiving and providing assurance that the trust has an appropriate pay and reward system linked to delivery of the organisation's strategic objectives, outcomes and desired behaviours
- making sure the training and education provided and commissioned by the trust is fully aligned to the trust's strategy
- making sure there are mechanisms to support the mental and physical health and wellbeing of the trust's staff
- receiving information on strategic themes relating to employment issues, making sure they are understood and actioned

- making sure the trust is compliant with relevant legislation and regulations relating to workforce matters
- reviewing risks which have been assigned to the committee and providing assurance that key controls and action plans are adequate to address gaps in controls
- making sure the trust has appropriate workforce policies in place.

Members of the strategic workforce committee include two non-executive directors (one as chair), director of workforce, organisational development and communications; chief operating officer; chief nurse and medical director. The deputy director of finance and deputy director of workforce are also members.

6.2.8 Executive Team

The Executive Team operates on behalf of the trust Board to make sure Kent Community Health NHS Trust operates efficiently and effectively in the development and implementation of strategy, operational plans, policies and procedures. The Executive Team will peer review operating and financial performance; strategic, corporate and operational risk; discuss and quality assure documents and issues before they are reported to the Board and its committees. This provides the opportunity for cross directorate engagement and appropriate delegation of work:

- to make sure the effective operational management of the trust
- development of corporate and business strategy, operational plans, policies and procedures and objectives for recommendations to the trust Board and its committees
- provide a forum for key policy areas to be debated and refined
- review operational, financial, risk and performance of the trust
- validate all newly identified high risks to make sure risks are accurately described and rated
- make sure the trust remains fit for purpose by continuously reviewing effectiveness and efficiency of management and leadership
- formulate and implement service changes and developments
- seek ways to continuously improve the quality of working life for employees
- seek ways to continually improve the patient experience and engagement
- ensure effective partnership working across the health economy

7. NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to make sure all employer obligations contained within the scheme regulations are complied with.

This includes making sure deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

8. Sustainability

In support of the NHS Long Term Plan and sustainability agenda, our vision is to be a leading provider of outstanding low-carbon care to our patients and staff, which incorporates the seven elements of sustainability and resource efficiency. Our aim is to reduce our carbon footprint by 50 percent over the next five years.

In October 2020, Kent Community Health NHS Foundation Trust agreed a set of 41 actions as part of the trust's Sustainability Strategy 2021/26. At the core of this strategy is a focus on the health of the communities we serve now and for generations to come. The dedicated sustainability lead position has been created to progress and report against this strategy, consistent with our commitment to the NHS Long Term Plan and sustainability agenda. The trust's strategy targets five broad areas: Journeys, the built environment, supply, wildlife and biodiversity, and our people.

9. Workforce

The trust ensures short, medium and long-term workforce strategies and staffing systems are in place which assures the Board staffing processes are safe, sustainable and effective.

Assurance is provided through the trust's Strategic Workforce Committee, People Strategy, related KPIs and action plans. Workforce risks are also managed throughout the trust's committee structures.

The Executive Team receives a monthly report on safe staffing as does the Quality Committee. The Executive and Strategic Workforce Committee make sure this is reported to the Board. The requirements of the 2016 NQBs guidance is responded to in the safe staffing reports.

To support safe staffing, the trust uses evidence-based tools, developed against national requirements and local specifics in terms of acuity and need. The forward rotas, outcomes and lessons learned are regularly considered and monitored by professionals at different levels of seniority with a clear reporting and assurance process through line management, the executive and the Quality Committee to the Board. I receive assurance through the chief nurse and medical director that staffing rotas are safe, effective and sustainable.

The workforce plan is developed annually to fundamentally assure safe care and to deliver the trust's objectives, developments and goals. The plan is reviewed by the Executive and Strategic Workforce Committee.

10. Review of economy, efficiency and effectiveness of the use of resources

The Board takes responsibility for oversight and risk management assurance throughout the trust and receives the Board Assurance Framework at its formal meetings.

The trust's strategic goals form the basis of the Board Assurance Framework. The strategic goals are linked to key risks, internal controls and assurance sources. Mitigating controls and assurances are recorded and monitored to deliver reasonable assurance for prevention of risks, deterrent to risks arising and management of current risks. The control mechanisms in place are designed to minimise or eliminate the risk of failure to deliver business objectives, including robust corporate and performance management frameworks, service level agreements and contract monitoring, policies and procedures.

The Board delegated detailed oversight of the Board Assurance Framework to the Audit and Risk Committee. This committee assesses the effectiveness of risk management by: Managing and monitoring the implementation of the Risk Management Strategy; considering findings from internal and external audit reviews; calling executive directors to account for their risk portfolios and monitoring the Board Assurance Framework at each of its meetings. The Audit and Risk Committee is supported by the corporate services director who produces regular reports on risk for review.

The end of year review of the Board Assurance Framework by audit has resulted in an opinion of reasonable assurance that the Board Assurance Framework is effective.

Clinical risk and patient safety are overseen by the trust Quality Committee, the chief nurse, the medical director and the operational director. The Board receives monthly quality reports encompassing the quality and patient safety aspects for the trust. The Quality Committee has focused on assurance that the trust is embedding the lessons identified from incidents across the trust. It has also sought assurance on the progress of the action plans that were developed in relation to the Trust's NHS Improvement Quality Governance Assurance Framework score, and the Care Quality Commission's inspection of the trust. This assurance is Kent Community Health NHS Foundation Trust annual report, quality report and accounts 2020 to 2021 reported to the Board.

Specialised risk management activities, for example, emergency planning and business continuity, health, safety, fire and security, are carried out by the Corporate Assurance and Risk Management Group that reports to the Executive Team and is accountable to the Audit and Risk Committee.

The Audit and Risk Committee receives regular reports from the local counter fraud specialist which identifies specific fraud risks and investigates whether or not there was evidence of those being exploited. No significant risks, classes of transactions or account balances were identified. The committee has focused some attention on the relationship between claims and the associated costs, and incidents reported.

Control measures are in place to make sure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. These include policies, the committee structure and Board assessment of compliance with, and progress against, equality and diversity best practice.

The trust has published an up-to-date register of interests for decision-making staff within the past 12 months.

The impact of the COVID-19 pandemic and the challenges of resetting has touched every area of trust work and operation and for the purposes of this statement, is included as a significant control issue. This is on the basis that the annual plan, goals and finances were significantly impacted.

11. Information governance

The trust takes all information governance incidents very seriously and, regardless of severity, are analysed and where appropriate categorised as a serious incident needing further investigation. For the period 1 April 2020 to 31 March 2021, there were two serious incidents reported to the regulatory body, the Information Commissioner. The Information

Commissioner's Office responded and did not take any action against the trust in respect of either incident.

12. Emergency preparedness, resilience and response

The trust has a duty to prepare for emergencies and to have plans in place to make sure it returns to business as usual as soon as possible following an event. The trust has developed a comprehensive management framework to make sure it complies with the NHS Core standards of emergency preparedness, resilience and response. The framework confirms the trust has quality tested business continuity plans and these are regularly tested through a range of exercises.

For 2020/21, the trust gained fully compliant status within the annual assurance assessment. In 2020/21, the government declared a level four incident in relation to COVID-19. The trust responded to this incident using its emergency planning and business continuity plans.

13. Review of effectiveness

As accounting officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Committee and Quality Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

There is a clear, dynamic process for monitoring progress against audit recommendations with oversight by the Audit and Risk Committee. Recommendations from any reports providing limited assurance are prioritised.

Director statements from executive directors and senior managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed and addressed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board supported by the Audit and Risk and Quality committees' regular reports to the Board.

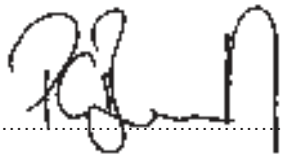
Processes are in place to maintain and review the effectiveness of the system of internal control by:

- the Board providing overall leadership for the management of risk against the achievement of organisational objectives
- the Board's receipt of the Board Assurance Framework at its meetings
- the Audit and Risk Committee and the Corporate Assurance and Risk Management Group providing assurance on the effective operation of the risk management system
- each level of management being responsible for the risks in their areas, regularly reviewing them and the controls in place to mitigate them
- the internal assurance process used to monitor compliance with the Care Quality Commission Essential Standards.

The impact of the COVID-19 pandemic has touched every area of trust's work and operation and for the purposes of this statement, is included as a significant control issue. This is on the basis that the annual plan, goals and finances were significantly impacted.

14. Conclusion

My review confirms that Kent Community Health NHS Foundation Trust has a sound system of internal control. The Head of Internal Audit has assessed Kent Community Health NHS Foundation Trust and given the trust a rating of reasonable assurance overall which supports the achievement of the goals, vision, values, policies, aims and objectives of the organisation.

Signed.....  .....

Paul Bentley, Chief Executive Officer

Date: 17 June 2021

NHS Oversight Framework

'NHS Improvement, incorporating the former foundation trust regulator, Monitor, is the regulator for health services in England and has a role to protect and promote the interests of patients.'

The NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework is intended to:

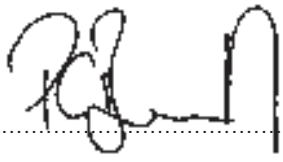
- provide one framework to oversee providers, irrespective of their legal form
- help them identify problems, and risks of problems, as they emerge
- pinpoint the source of the problem, allowing them to tailor their support packages to the specific needs of providers and local health systems.

Segmentation

NHS Improvement will segment providers into four groups based on information relating to the five themes, and will specify the level of support required for each provider on this basis.

The latest segmentation information available as at 31 March 2021 places Kent Community Health NHS Foundation Trust in segment two.

The trust's Board considers performance against national priorities set out in the NHS Oversight Framework for NHS Providers, which sets out how NHS Improvement works alongside trusts to support the delivery of high quality and sustainable services for patients.

Signed 

Paul Bentley, Chief Executive Officer

Date: 17 June 2021

Independent auditor's report to the Council of Governors of Kent Community Health NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Kent Community Health NHS Foundation Trust (the 'Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of the other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2020/21 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer set out on page 66, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2020/21, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those Charged with Governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit and Risk Committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, Internal Audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.

- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and any other fraud risks identified for the audit.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on large and unusual journals;
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of property, plant and equipment valuations and **[include details];**
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to land and building valuations, depreciation, provisions, accruals and credit loss and impairment allowances.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's.
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

25 June 2021

Independent auditor's report to the Council of Governors of Kent Community Health NHS Foundation Trust

In our auditor's report issued on 25 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 25 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Kent Community Health NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Sarah L Ironmonger

Sarah Ironmonger, Key Audit Partner

for and on behalf of Grant Thornton UK LLP, Local Auditor

London

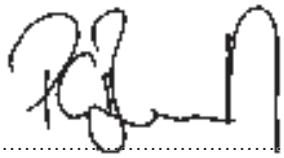
2 September 2021

Annual accounts for the year ended 31 March 2021

Foreword to the accounts

Kent Community Health NHS Foundation Trust

These accounts, for the year ended 31 March 2021, have been prepared by Kent Community Health NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed  Date 17 June 2021

Name Paul Bentley
Job title Chief Executive Officer

Statement of comprehensive income
for the year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Operating income from patient care activities	3	247,487	237,120
Other operating income	4	21,804	13,285
Operating expenses	6, 8	(269,549)	(248,102)
Operating surplus/(deficit) from continuing operations		**(258)**	**2,303**
Finance income	11		253
Finance expenses	12	(13)	(1)
PDC dividends payable			(36)
Net finance costs		**(13)**	**216**
Surplus/(deficit) for the year from continuing operations		**(271)**	**2,519**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		–	–
Surplus/(deficit) for the year		**(271)**	**2,519**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(669)	125
Revaluations	15	468	380
Gain/(loss) arising from on transfers by modified absorption	34	420	
Total comprehensive income/(expense) for the period		**(52)**	**3,024**

The notes on pages 94 to 127 form part of this account.

Statement of financial position
as at 31 March 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	13	1,453	652
Property, plant and equipment	14	24,650	19,569
Receivables	19	238	414
Total non-current assets		**26,341**	**20,635**
Current assets			
Inventories	18	–	–
Receivables	19	17,471	17,938
Non-current assets for sale and assets in disposal groups	20	295	–
Cash and cash equivalents	21	42,859	44,666
Total current assets		**60,625**	**62,604**
Current liabilities			
Trade and other payables	22	(31,942)	(34,023)
Provisions	26	(367)	(889)
Other liabilities	23	(4,526)	(1,774)
Total current liabilities		**(36,835)**	**(36,686)**
Total assets less current liabilities		**50,131**	**46,553**
Non-current liabilities			
Provisions	26	(718)	(788)
Total non-current liabilities		**(718)**	**(788)**
Total assets employed		**49,413**	**45,765**
Financed by			
Public dividend capital		6,589	2,889
Revaluation reserve		1,166	1,199
Income and expenditure reserve		41,658	41,677
Total taxpayers' equity		**49,413**	**45,765**

The notes on pages 94 to 127 form part of this account.

The financial statements on pages 89 to 93 were approved by the Board on 17 June 2021 and signed on its behalf by:

Signed ..... Date 17 June 2021

Name Paul Bentley
Job title Chief Executive Officer

Statement of changes in equity
for the year ended 31 March 2021

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2020 – brought forward	**2,889**	**1,199**	**41,677**	**45,765**
Surplus/(deficit) for the year	–	–	(271)	**(271)**
Gain/(loss) arising from transfers by modified absorption	–	–	420	**420**
Transfers by absorption: Transfers between reserves	–	168	(168)	**–**
Impairments	–	(669)	–	**(669)**
Revaluations	–	468	–	**468**
Public dividend capital received	3,700	–	–	**3,700**
Taxpayers' equity at 31 March 2021	**6,589**	**1,166**	**41,658**	**49,413**

Statement of changes in equity
for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2019 – brought forward	**2,889**	**694**	**39,158**	**42,741**
Surplus/(deficit) for the year	–	–	2,519	**2,519**
Impairments	–	125	–	**125**
Revaluations	–	380	–	**380**
Taxpayers' equity at 31 March 2020	**2,889**	**1,199**	**41,677**	**45,765**

Information on reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital used by the trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

The trust received additional PDC of £3,700k during 2020/21 following application to the Department of Health and Social Care for centrally allocated capital funding programmes (£2,139k Health Service Lead Investment in Provider Digitisation; £1,356k Urgent and Emergency Care (Urgent Treatment Centres); £113k Cyber Security; £92k COVID-19 Response).

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Statement of cash flows
for the year ended 31 March 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating surplus/(deficit)		(258)	2,303
Non-cash income and expense:			
Depreciation and amortisation	6	3,767	3,147
Net impairments	7	373	(22)
(Increase)/decrease in receivables and other assets		291	8,055
Increase/(decrease) in payables and other liabilities		1,341	9,484
Increase/(decrease) in provisions		(603)	(104)
Net cash flows from/(used in) operating activities		**4,911**	**22,863**
Cash flows from investing activities			
Interest received		6	259
Purchase of intangible assets		(1,001)	(230)
Purchase of PPE and investment property		(9,768)	(5,318)
Net cash flows from/(used in) investing activities		**(10,763)**	**(5,289)**
Cash flows from financing activities			
Public dividend capital received		3,700	–
Other interest		(2)	(1)
PDC dividend (paid)/refunded		347	(284)
Net cash flows from/(used in) financing activities		**4,045**	**(285)**
Increase/(decrease) in cash and cash equivalents		**(1,807)**	**17,289**
Cash and cash equivalents at 1 April – brought forward		**44,666**	**27,377**
Cash and cash equivalents at 31 March	**21**	**42,859**	**44,666**

The notes on pages 94 to 127 form part of this account.

Notes to the accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 issued by the Department of Health and Social Care (DHSC). The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Note 1.3 Interests in other entities

NHS Charitable Fund

The trust is the corporate trustee of Kent Community Health Charitable Fund. The trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. However, the transactions are immaterial in the context of the group and transactions have not been consolidated. Details of the transactions with the charity are included in the related parties' notes.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the trust accrues income relating to performance obligations satisfied in that year. Where the trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Satisfaction of performance obligations will result in immediate payment (in cases of verbal or implied contracts) or creation of a contract receivable with payment from the customer expected in line with the credit terms outlined in the relevant written contract.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a sustainability and transformation partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the trust's entitlement to consideration not varying based on the levels of activity performed.

The trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income are accounted for as variable consideration.

Comparative period (2019/20)

In the comparative period (2019/20), the trust's contracts with NHS commissioners for health care services was also the main source of income. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the trust accrued income relating to the delivery of health care services in that year not yet invoiced or paid. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In the event a contract or invoice was challenged, revenue was recognised to the extent that collection of the consideration was probable.

The trust received income in 2019/20 from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The CQUIN payments were not considered distinct performance obligations in their own right; instead they formed part of the transaction price for performance obligations under the contract. In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds was accounted for as variable consideration.

For 2020/21 and 2019/20

In applying IFRS 15, a number of practical expedients offered in the Standard and mandated by the GAM have been employed. These are as follows:

- as per paragraph 121 of the Standard, the trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less;
- the trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with the value of the performance completed to date.

Note 1.4.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. During 2020/21, the trust received a grant (Community Infrastructure Levy Receipts) from Sevenoaks District Council (refer to note 23 for further information).

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.2 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period. Payments for overtime and enhancements are paid one month in arrears and the accounts presented incorporate an accrual for the cost of overtime and enhancements worked in March 2021 but to be paid in April 2021.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The schemes are not designed in a way that would enable employers to identify their share of the underlying scheme's assets and liabilities. Therefore, the schemes are accounted for as though they are defined contribution schemes: The cost to the trust is taken as equal to the employer's pension contributions payable to the schemes for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the schemes except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

National Employment Savings Trust (NEST)

The Pensions Act 2008 (the Act) introduced a new requirement for employers to automatically enrol any eligible job holders working for them into a workplace pension scheme that meets certain requirements and provides a minimum employer contribution. Where an employee is eligible to join the NHS Pension Scheme then they will be automatically enrolled into this scheme. However, where an employee is not eligible to join the NHS Pension Scheme, an alternative scheme must be made available by the trust. The trust's alternative scheme is NEST. NEST is a defined contribution pension scheme that was created as part of the Government's workplace pensions reforms under the Pensions Act 2008. Employers' pension cost contributions are charged to operating expenses as and when they become due.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control
- items forming part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, such as plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Subsequent measurement is as follows:

- Assets held for their service potential and are in use (for example operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. For in use non-specialised property assets, current value in existing use should be interpreted as market value for existing use.
- Specialised assets are held at current value in existing use which is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential.
- Assets held for their service potential but are surplus are valued at current value in existing use, if there are restrictions on the trust or the asset which will prevent access to the market at the reporting date. If the trust can access the market then the surplus asset is valued at fair value using IFRS 13.
- Assets which are not held for their service potential are valued in accordance with IFRS 5 or IAS 40 depending on whether the asset is actively held for sale.
- Assets which are not being used to deliver services and there is no plan to bring it back into use, with no restrictions on sale, and do not meet the IFRS 5 and IAS 40 criteria, these assets are considered surplus and are valued at fair value using IFRS 13.

IFRS 13 Fair Value is adopted in full, however, IAS 16 and IAS 38 have been adapted and interpreted for the public sector context which limits the circumstances in which a valuation is prepared under IFRS 13.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- land and non-specialised buildings – market value for existing use
- specialised buildings – depreciated replacement cost on a modern equivalent asset basis
- leasehold improvements – in respect of buildings for which the trust is a lessee under an operating lease will be depreciated over the lease duration (or other period deemed appropriate) and carried at depreciated historic cost, as this is not considered to be materially different from current value. Thus, improvements are not revalued, and no indexation is applied as the adjustments which would arise are not considered material.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23. Assets are revalued and depreciation commences on assets when they are brought into use, other than grouped information technology (IT) assets. Depreciation starts on grouped IT assets on receipt by the trust and not when the separable parts are brought into use, as this is more practicable by alleviating the requirement to depreciate the assets individually.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated useful life of an asset is the period over which the trust expects to obtain economic benefits or service potential from the asset. This is specific to the trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
- the sale must be highly probable for example:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings*	1	35
Plant and machinery	1	12
Transport equipment	2	4
Information technology	1	10
Furniture and fittings	1	4

*Category consists of both trust-owned properties and leasehold improvements and the minimum life stated recognises the short-term nature of some of the leases in place.

Note 1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust, where the cost of the asset can be measured reliably and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the trust intends to complete the asset and sell or use it
- the trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, such as the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

Software that is integral to the operation of hardware, such as an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	1	5

Note 1.9 Inventories

The trust holds no material inventories. Community hospitals hold consumables to cover approximately one week's consumption. Consumable expenditure is charged directly to operating expenses. In response to the COVID-19 pandemic, the Department of Health and Social Care (DHSC) centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the trust received £3,669k of items purchased by DHSC. In line with the trust's accounting policy for inventories, the deemed cost of these inventories was charged directly to expenditure on receipt with the corresponding benefit recognised in income (as referenced in Note 4 and Note 6).

Note 1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

Note 1.11 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS. This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which,

performance occurs, for example when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

The trust's financial assets and financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

The trust's financial assets consist of cash and cash equivalents; and contract and other receivables. The trust has not issued any loans and does not currently hold any financial assets with different characteristics to their host contract for example derivatives. The trust's financial liabilities consist of trade and other payables. The trust does not have any loans, financial guarantee liabilities or other financial liabilities.

Impairment of financial assets

For financial assets measured at amortised cost, for example contract and other receivables, the trust recognises an allowance for expected credit losses. The trust adopts the simplified approach to impairment for contract and other receivables, measuring expected losses as at an amount equal to lifetime expected losses. The expected credit loss for contract and other receivables is determined by separately categorising contract and other receivables into specific classes of debt, for example by type of debt and common credit characteristics. This classification exercise is completed on review of historical credit loss experience for each type of debt and modified to reflect current and forecast economic conditions. In devising such a provision matrix and in line with the GAM, the trust has excluded the recognition of expected credit losses in relation to other DHSC bodies as it is deemed that the DHSC will provide a guarantee of last resort against the debts of DHSC bodies. Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. The trust does not currently have any finance leases.

All other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Note 1.13 Provisions

The trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 26.1 but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.14 Contingencies

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in note 27, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the relevant Department of Health and Social Care policy, such as average daily cash balances held with the Government Banking Service.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

As a result of the trust's average daily cash balances held with the Government Banking Service during 2020/21 being in excess of its calculated average relevant net assets, the trust's PDC dividend expense for 2020/21 is nil.

Note 1.16 Value added tax

Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation tax

The trust has determined that it is has no corporation tax liability on the basis it has no activities subject to corporation tax as all activities are core or related to core healthcare as defined in Health and Social Care Act legislation.

Note 1.18 Foreign exchange

The trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are re-translated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

Note 1.19 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.20 Losses and special payments

Losses and special payments are items that parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the

way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Modified absorption accounting – transfer of former primary care trust assets to NHS providers

Transfers of former primary care trust assets from NHS Property Services to NHS providers under the DHSC asset transfer policy announced in May 2019, is accounted for via a modified absorption approach with the gain on transfer recognised directly in reserves (income and expenditure reserve).

For property, plant and equipment assets, the cost and accumulated depreciation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Note 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.23 Standards, amendments and interpretations in issue but not yet effective or adopted.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right use asset and obligation in the statement of financial position for most leases; some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position, the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For leases starting in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

Other standards, amendments and interpretations

The following issued accounting standard has not yet been adopted by the HM Treasury FReM and are therefore not applicable in 2020/21:

- IFRS 17 Insurance Contracts – application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be from April 2023 (early adoption is not permitted).

Note 1.24 Critical accounting estimates and judgements

In the application of the trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The following are the bases for the estimations that management have used in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements (note 26 provides further analysis of the provisions accounted):

Redundancy provision

A provision has been recognised in respect of redundancy as a result of service changes and other events, based on estimated probabilities as advised by expert opinion within the trust.

Legal Claims and other provisions

The trust has received expert opinion from external advisers as to the expected value, the assumptions on the timing of the associated cashflow and the probability of such costs being settled.

Valuation of Land and Buildings (owned)

This is based on the professional judgement of the trust's independent valuer with extensive knowledge of physical estate within the NHS and market factors.

The COVID-19 pandemic and measures taken to respond to the crisis continue to effect economies and real estate markets globally. Nevertheless, as at the valuation date property markets are mostly functioning again, with transaction volumes and other relevant evidence at levels where an adequate quantum of market evidence exists upon which to base opinions of value. Accordingly, and for the avoidance of doubt, the valuation provided by the appointed valuer as at 31 March 2021, is not reported as being subject to a 'material valuation uncertainty' as defined by RICs Valuation Global Standards.

The trust has not made any other assumptions concerning the future or applied any estimations that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 2 Operating segments

The trust does not produce any segmental analysis for any individual elements of the trust's operations. Indicative Service Line Reporting for income and expenditure is produced as management information. Assets and liabilities are not segmented.

The majority of funding was provided by clinical commissioning groups, local authorities and NHS England. Revenue for patient care and other operating activities from these bodies was as follows:

	2020/21 £000	% of total revenue
Clinical commissioning groups	162,748	60.44%
Local authorities	44,227	16.42%
NHS England	34,719	12.89%
Total	**241,694**	**89.75%**

	2019/20 £000	% of total revenue
Clinical commissioning groups	154,387	61.65%
Local authorities	44,853	17.91%
NHS England	24,877	9.93%
Total	**224,117**	**89.50%**

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from patient care activities (by nature)

	2020/21 £000	2019/20 £000
Community services		
Block contract/system envelope income*	185,234	173,532
Income from other sources (such as local authorities)	53,347	54,577
All services		
Private patient income	23	77
Additional pension contribution central funding**	8,131	7,372
Other clinical income	752	1,562
Total income from activities	**247,487**	**237,120**

*As part of the coronavirus COVID-19 pandemic response, transaction flows were simplified in the NHS and providers and commissioners moved on to block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3 per cent to 20.6 per cent (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers has continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:

	2020/21 £000	2019/20 £000
NHS England	32,669	29,825
Clinical commissioning groups	161,448	152,641
Other NHS providers	7,007	7,320
Local authorities	44,227	44,853
Non-NHS: Private patients	23	77
Injury cost recovery scheme	306	387
Non NHS: Other	1,807	2,017
Total income from activities	**247,487**	**237,120**
Of which:		
Related to continuing operations	247,487	237,120
Related to discontinued operations	–	–

Note 4 Other operating income

	2020/21			2019/20		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Education and training	2,010	831	**2,841**	1,553	585	**2,138**
Non-patient care services to other bodies	4,454	–	**4,454**	6,398	–	**6,398**
Provider sustainability fund (2019/20 only)	–	–	–	2,313	–	**2,313**
Reimbursement and top up funding	9,814	–	**9,814**	–	–	–
Charitable and other contributions to expenditure	–	3,696	**3,696**	–	40	**40**
Other income	999	–	**999**	2,396	–	**2,396**
Total other operating income	**17,277**	**4,527**	**21,804**	**12,660**	**625**	**13,285**
Of which:						
Related to continuing operations			**21,804**			**13,285**
Related to discontinued operations			–			–

Included within 2020/21 non-patient care services to other bodies is income of £2.4m (£4.5m 2019/20) relating to the Kent and Medway Sustainability and Transformation Partnership (K&M STP). The trust agreed to become the financial host of the K&M STP budget from 1 October 2019 to 30 September 2020. This funding was provided in accordance with agreements made by each K&M STP partner with the K&M STP Board to cover the costs of the planned annual programme. As of 1 October 2020, financial hosting of the K&M STP budget transferred to NHS Kent and Medway Clinical Commissioning Group. The associated costs of the K&M STP incurred during the period of the trust's hosting arrangement are reported within the trust's operating expenses in note 6.

Reimbursement and top-up funding represents the value of additional income received from NHS England outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services during 2020/21. £3.4m of this funding relates to the reimbursement of specific costs incurred by the trust in the preparation and operation of the COVID-19 vaccination programme during 2020/21. The costs of the COVID-19 vaccination programme are included in the trust's operating expenses in note 6.

Charitable and other contributions to expenditure includes £3,669k of income representing the benefit of the deemed cost of inventories (personal protective equipment consumables) received from the Department of Health and Social Care at nil cost during 2020/21. As outlined in note 1.9, the corresponding expense representing the deemed cost of these inventories has been charged directly to expenditure and is included in the trust's operating expenses in note 6.

The education and training income presented as non-contract income represents the value of benefit arising from apprenticeship levy funded training received. The corresponding notional expense is recognised within education and training costs in note 6.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2020/21 £000	2019/20 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	1,421	1,364

Note 5.2 Transaction price allocated to remaining performance obligations

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 5.3 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2020/21 £000	2019/20 £000
Income from services designated as commissioner requested services	–	–
Income from services not designated as commissioner requested services	269,291	250,405
Total	**269,291**	**250,405**

In line with guidance from NHS Improvement, all foundation trusts' mandatory services were designated as 'Commissioner Requested Services' when licensing began. However commissioners were required to review this designation by 1 April 2016 and, as a result, none of the trust's services provided since 1 April 2016 have been designated as commissioner requested.

Note 6 Operating expenses

	2020/21 £000	2019/20 £000
Staff and executive directors costs	195,611	177,356
Remuneration of non-executive directors	190	163
Supplies and services – clinical (excluding drugs costs)	28,508	22,323
Supplies and services – general	2,165	1,209
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	4,211	4,678
Consultancy costs	1,879	3,940
Establishment	8,081	7,523
Premises	9,037	9,199
Transport (including patient travel)	3,063	5,345
Depreciation on property, plant and equipment	3,447	2,957
Amortisation on intangible assets	320	190
Net impairments	373	(22)
Movement in credit loss allowance: Contract receivables / contract assets	41	(18)
Movement in credit loss allowance: All other receivables and investments	13	53
Audit fees payable to the external auditor	–	–
audit services – statutory audit*	78	64
Internal audit costs	51	92
Clinical negligence	730	522
Legal fees	295	951
Insurance	162	144
Education and training	1,975	1,813
Rentals under operating leases	8,719	9,308
Redundancy	62	(161)
Hospitality	6	37
Losses, ex gratia and special payments	26	2
Other services, such as external payroll	374	301
Other	132	133
Total	**269,549**	**248,102**
Of which:		
Related to continuing operations	269,549	248,102
Related to discontinued operations	–	–

Total operating expenditure on the COVID-19 response during 2020/21 was £11.3m (£6.4m of staff costs), of which £3.4m (£2.4m of staff costs) related to the COVID-19 vaccination programme.

Supplies and services – clinical (excluding drugs costs) includes £3,669k deemed cost of inventories (personal protective equipment consumables) received from the Department of Health and Social Care at nil cost during 2020/21 and charged directly to expenditure on receipt (see also note 1.9 and note 4).

*The audit fees payable to the external auditor as presented in the above note include irrecoverable VAT.

Note 6.1 Limitation on auditor's liability

The auditor's liability for external audit work carried out for the financial year 2020/21 is limited to £2,000,000.

Note 7 Impairment of assets

	2020/21 £000	2019/20 £000
Net impairments charged to operating surplus/deficit resulting from:		
Changes in market price	373	(22)
Total net impairments charged to operating surplus/deficit	**373**	**(22)**
Impairments charged to the revaluation reserve	669	(125)
Total net impairments	**1,042**	**(147)**

The impairment values reported follow the full revaluation exercise carried out of the trust's owned properties (land and buildings) as at 31 March 2021. On physical review of the trust's estate, the valuer has confirmed a reduction in the value of Foster Street Clinic (£511k) and Hawkhurst Community Hospital (£379k) following an assessment of the current usage and occupation by the trust at the respective sites. The outcome of this independent assessment has been agreed by the trust's Estates Department.

The valuer also reported a reduction in the value of College Road Clinic land (£152k) as at 31 March 2021 following its transfer to the trust on 1 March 2021 from NHS Property Services (please also refer to Note 34 for further details of the transfer). The reduction in value is in the main due to the difference in valuation methodology adopted by the trust and the previous owner (NHS Property Services).

Note 8 Employee benefits

	2020/21 £000	2019/20 £000
Salaries and wages	149,688	135,634
Social security costs	12,741	11,351
Apprenticeship levy	715	645
Employer's contributions to NHS pensions	26,894	24,309
Pension cost – other	48	47
Termination benefits	91	171
Temporary staff (including agency)	6,913	6,571
Total gross staff costs	**197,090**	**178,728**
Recoveries in respect of seconded staff	(9)	(299)
Total staff costs	**197,081**	**178,429**
Of which		
Costs capitalised as part of assets	1,379	902

The employer contribution rate for NHS pensions increased from 14.3 per cent to 20.6 per cent (excluding administration levy) from 1 April 2019. For 2020/21, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on the providers' behalf. The increased cost in employer's contributions (2020/21 £8,131k and 2019/20 £7,372k) is recognised in full in the figures presented above, with the commensurate notional funding from NHS England for the respective year being recognised in note 3.1.

Total staff costs on the COVID-19 response during 2020/21 were £6.4m, of which £2.4m related to the COVID-19 vaccination programme.

Note 8.1 Retirements due to ill-health

During 2020/21 there were four early retirements from the trust agreed on the grounds of ill-health (two in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £248k (£154k in 2019/20).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: The cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This uses an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury has also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6 per cent, of pensionable pay. The 2016 funding valuation was also expected to test the cost of the scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Other schemes

The trust participates in the National Employees Savings Trust (NEST) scheme as an alternative for those employees who are not eligible to join the NHS Pension scheme. NEST is a defined contribution scheme with a phased employer contribution rate, currently 3 per cent.

Note 10 Operating leases

Note 10.1 Kent Community Health NHS Foundation Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Kent Community Health NHS Foundation Trust is the lessee.

	2020/21 £000	2019/20 £000
Operating lease expense		
Minimum lease payments	8,719	9,308
Contingent rents	–	–
Less sublease payments received	–	–
Total	**8,719**	**9,308**

	31 March 2021 £000	31 March 2020 £000
Future minimum lease payments due:		
– not later than one year;	2,743	2,665
– later than one year and not later than five years;	5,411	5,730
– later than five years.	3,457	3,900
Total	**11,611**	**12,295**
Future minimum sublease payments to be received	–	–

Future lease commitments include only those leases with formal lease contracts in place as at 31 March 2021.

On 1 March 2021, the trust assumed a direct tenant relationship with the freeholder of Tonbridge Cottage Hospital, from NHS Property Services. This followed the expiry of the pre-existing lease between the freeholder of Tonbridge Cottage Hospital and NHS Property Services. As at 31 March 2021, the proposed terms of a lease between the trust and the freeholder are still to be finalised and no formal lease agreement is in place for Tonbridge Cottage Hospital between the trust (as lessee) and the freeholder.

Note 11 Finance income

Finance income represents interest received on assets and investments in the period.

	2020/21 £000	2019/20 £000
Interest on bank accounts	–	253
Total finance income	**–**	**253**

From 19 March 2020 and throughout 2020/21 the rate of interest the HM Treasury National Loans Fund pays to Government Banking Service customers with interest-bearing accounts has been 0.0 per cent (zero percent).

Note 12 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21 £000	2019/20 £000
Interest expense:		
Interest on late payment of commercial debt	2	1
Total interest expense	**2**	**1**
Unwinding of discount on provisions	11	–
Total finance costs	**13**	**1**

Note 12.1 The late payment of commercial debts (interest) Act 1998/Public Contract Regulations 2015

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2020/21 £000	2019/20 £000
Amounts included within interest payable arising from claims made under this legislation	2	1

Note 13 Intangible assets – 2020/21

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2020 – brought forward	**884**	**251**	**1,135**
Additions	1,081	40	**1,121**
Reclassifications	251	(251)	–
Disposals/derecognition	(28)	–	(28)
Valuation/gross cost at 31 March 2020	**2,188**	**40**	**2,228**
Amortisation at 1 April 2020 – brought forward	**483**	–	**483**
Provided during the year	320	–	320
Disposals/derecognition	(28)	–	(28)
Amortisation at 31 March 2021	**775**	-	**775**
Net book value at 31 March 2021	**1,413**	**40**	**1,453**
Net book value at 1 April 2020	**401**	**251**	**652**

Note 13.1 Intangible assets – 2019/20

	Software licences £000	Intangible assets under construction £000	Total £000
Valuation/gross cost at 1 April 2019	**841**	–	**841**
Additions	43	251	**294**
Disposals/derecognition	–	–	–
Valuation/gross cost at 31 March 2020	**884**	251	**1,135**
Amortisation at 1 April 2019	**293**	–	**293**
Provided during the year	190	–	**190**
Amortisation at 31 March 2020	**483**	–	**483**
Net book value at 31 March 2020	**401**	251	**652**
Net book value at 1 April 2019	**548**	–	**548**

Note 14 Property, plant and equipment – 2020/21

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Valuation/gross cost at 1 April 2020 – brought forward	**1,472**	**9,631**	**2,882**	**2,966**	**185**	**16,814**	**979**	**34,929**
Transfers by absorption*	247	205	-	-	**-**	-	-	452
Additions	-	1,978	3,207	173	-	3,589	30	8,977
Impairments	(641)	(401)	-	-	-	-	-	(1,042)
Reversals of impairments	-	-	-	-	-	-	-	-
Revaluations	40	210	-	-	-	-	-	250
Reclassifications	295	678	(2,546)	196	-	1,377	**-**	-
Transfers to/from assets held for sale	(295)	**-**	**-**	**-**	**-**	**-**	**-**	**(295)**
Disposals / derecognition	**-**	-	-	-	-	(4,554)	-	(4,554)
Valuation/gross cost at 31 March 2021	**1,118**	**12,301**	**3,543**	**3,335**	**185**	**17,226**	**1,009**	**38,717**
Accumulated depreciation at 1 April 2020 – brought forward	-	**2,901**	-	**1,427**	**178**	**9,995**	**859**	**15,360**
Transfers by absorption*	**-**	32	**-**	-	-	-	-	32
Provided during the year	-	761	-	275	3	2,346	62	3,447
Revaluations	-	(218)	-	-	-	-	-	(218)
Disposals/derecognition	-	-	-	-	-	(4,554)	-	(4,554)
Accumulated depreciation at 31 March 2021	-	**3,476**	-	**1,702**	**181**	**7,787**	**921**	**14,067**
Net book value at 31 March 2021	**1,118**	**8,825**	**3,543**	**1,633**	**4**	**9,439**	**88**	**24,650**
Net book value at 1 April 2020	**1,472**	**6,730**	**2,882**	**1,539**	**7**	**6,819**	**120**	**19,569**

*Represents the transfer of College Road Clinic (Margate, Kent) from NHS Property Services. Refer to Note 1.21 and Note 34 for further information on the accounting policy and transfer.

Note 14.1 Property, plant and equipment 2019/20

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Valuation/gross cost at 1 April 2019 – brought forward	**1,472**	**9,055**	**872**	**2,770**	**207**	**14,573**	**934**	**29,883**
Additions	-	271	2,843	183	-	3,394	56	**6,747**
Impairments	**-**	(12)	-	-	**-**	-	-	**(12)**
Reversals of impairments	**-**	159	-	-	**-**	-	-	**159**
Revaluations	**-**	(14)	-	-	**-**	-	-	**(14)**
Reclassifications	-	408	(833)	178	-	247	-	**-**
Disposals/derecognition	-	(236)	-	(165)	(22)	(1,400)	(11)	**(1,834)**
Valuation/gross cost at 31 March 2020	**1,472**	**9,631**	**2,882**	**2,966**	**185**	**16,814**	**979**	**34,929**
Accumulated depreciation at 1 April 2019 – brought forward	-	**2,713**	-	**1,317**	**198**	**9,619**	**784**	**14,631**
Provided during the year	-	818	-	275	2	1,776	86	**2,957**
Revaluations	**-**	(394)	**-**	-	**-**	-	-	**(394)**
Disposals/derecognition	-	(236)	-	(165)	(22)	(1,400)	(11)	**(1,834)**
Accumulated depreciation at 31 March 2020	-	**2,901**	-	**1,427**	**178**	**9,995**	**859**	**15,360**
Net book value at 31 March 2020	**1,472**	**6,730**	**2,882**	**1,539**	**7**	**6,819**	**120**	**19,569**
Net book value at 1 April 2019	**1,472**	**6,342**	**872**	**1,453**	**9**	**4,954**	**150**	**15,252**

Note 14.2 Property, plant and equipment financing – 2020/21

	Land £000	Buildings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Net book value at 31 March 2021								
Owned – purchased	1,118	8,825	3,543	1,633	4	9,439	88	**24,650**
NBV total at 31 March 2021	**1,118**	**8,825**	**3,543**	**1,633**	**4**	**9,439**	**88**	**24,650**

Note 14.3 Property, plant and equipment financing – 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant and machinery £000	Transport equipment £000	Information Technology £000	Furniture and fittings £000	Total 000
Net book value at 31 March 2020								
Owned – purchased	1,472	6,730	2,882	1,539	7	6,819	120	**19,569**
NBV total at 31 March 2020	**1,472**	**6,730**	**2,882**	**1,539**	**7**	**6,819**	**120**	**19,569**

Note 15 Revaluations of property, plant and equipment

A full valuation exercise (physical inspection) was carried out of the trust's owned buildings and land as at 31 March 2021. This followed the full revaluation exercise carried out as at 31 March 2020. Adopting a prudent approach, the March 2021 valuation exercise was commissioned by the trust due to the declared material uncertainty on valuation information issued in March 2020 as a result of the uncertainties in markets caused by COVID-19 and the requirement to appoint a new surveyor in 2020/21 following the dissolution of the previous surveyor firm following the retirement of the partners. The valuation exercise carried out in March 2021 included the land and property of College Road Clinic (located in Margate, Kent) following its transfer to the trust on 1 March 2021 from NHS Property Services.

The trust's freehold estate consists of both specialised and non-specialised operational assets. In line with the RICs Valuation Global Standards, the basis for valuation used for the specialised operational assets is Depreciated Replacement Cost (DRC) method and the valuation methodology used for the non-specialised assets is Existing Use Value (EUV). Where buildings have been valued using the DRC method of valuation the assumption is that the replacement costs will reflect those of a modern equivalent asset (MEA). Due to the specialised nature of the operational assets valued using the depreciated replacement cost method of valuation, the value is not based on the sale of similar assets in the market. The value of operational assets held for their service potential do not reflect the market value for an alternative use which may be higher or lower than the reported value.

The revaluation exercise was carried out over the period to the end of March 2021, with a valuation date as at 31 March 2021 and was completed by Eleanor Cook MRICS of Montagu Evans LLP, an independent valuer with sufficient experience and qualifications. The valuation was prepared in accordance with the requirements of the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards.

As at the valuation date, property markets are mostly functioning again, with sufficient transaction volumes and other relevant evidence at levels where an adequate quantum of market evidence exists to form opinions of value. As a result, and unlike the valuation carried out as at 31 March 2020, the valuation information reported as at 31 March 2021 is not subject to 'material valuation uncertainty' as defined by VPS 3 and VPGA 10 of the RICs Valuation Global Standards.

Note 16 Investments 2019/20

The trust has no investments (including investments in property). Nil for March 2020.

Note 17 Disclosure of interests in other entities

The trust has no interests in other entities other than those disclosed in note 1.3

Note 18 Inventories

The trust holds no material inventories.

Note 19 Receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	14,561	15,345
Allowance for impaired contract receivables/assets	(67)	(31)
Allowance for other impaired receivables	(214)	(238)
Prepayments (non-PFI)	1,780	1,462
Interest receivable	-	6
PDC dividend receivable	-	346
VAT receivable	684	350
Other receivables	727	698
Total current receivables	**17,471**	**17,938**
Non-current		
Prepayments (non-PFI)	167	354
Other receivables	71	60
Total non-current receivables	**238**	**414**
Of which receivable from NHS and DHSC group bodies:		
Current	7,431	9,562
Non-current	71	60

Note 19.1 Allowances for credit losses

	2020/21		2019/20	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr – brought forward	**31**	**238**	**59**	**223**
New allowances arising	23	96	19	83
Changes in existing allowances	26	-	1	3
Reversals of allowances	(8)	(83)	(38)	(33)
Utilisation of allowances (write offs)	(5)	(37)	(10)	(38)
Allowances as at 31 Mar 2021	**67**	**214**	**31**	**238**

Note 20 Non-current assets held for sale and assets in disposal groups

	2020/21 £000	2019/20 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	–	–
Assets classified as available for sale in the year	295	–
NBV of non-current assets for sale and assets in disposal groups at 31 March	**295**	–

Land at Four Elms, Edenbridge in Kent was purchased by the trust in March 2020 from Kent County Council for the purposes of a proposed development of a new health and wellbeing centre in Edenbridge. The trust has now formally approved a plan to sell the land and a process to appoint a developer and buyer of the land has commenced.

Note 21 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2020/21 £000	2019/20 £000
At 1 April	**44,666**	**27,377**
Net change in year	(1,807)	17,289
At 31 March	**42,859**	**44,666**
Broken down into:		
Cash at commercial banks and in hand	35	51
Cash with the Government Banking Service	42,824	44,615
Total cash and cash equivalents as in SoFP	**42,859**	**44,666**
Total cash and cash equivalents as in SoCF	**42,859**	**44,666**

Note 21.1 Third party assets held by the trust

The trust held no cash and cash equivalents which relate to monies held by the trust on behalf of patients or other parties. Nil for 2019/20.

Note 22.1 Trade and other payables

	31 March 2021 £000	31 March 2020 £000
Current		
Trade payables	602	3,694
Capital payables	1,621	2,292
Accruals	22,709	22,161
Social security costs	2,395	2,171
Other taxes payable	1,535	1,241
PDC dividend payable	1	–
Other payables	3,079	2,464
Total current trade and other payables	**31,942**	**34,023**
Total non-current trade and other payables	**–**	**–**
Of which payables from NHS and DHSC group bodies:		
Current	9,328	13,199
Non-current	–	–

Note 22.1 Early retirements in NHS payables above

There are no early retirement payables. Nil for 2019/20.

Note 23 Other liabilities

	31 March 2021 £000	31 March 2020 £000
Current		
Deferred income: Contract liabilities	3,926	1,774
Deferred grants*	600	–
Total other current liabilities	**4,526**	**1,774**

*During 2020/21, the trust received a grant (Community Infrastructure Levy Receipts) for £600k from Sevenoaks District Council. The grant is to be used for the purposes of the Edenbridge integrated health and wellbeing centre project. The trust is currently working in partnership with Kent and Medway Clinical Commissioning Group and other health partners to oversee a project for the proposed appointment of a developer (and subsequent owner) of a new health and wellbeing centre in Edenbridge to replace the existing Edenbridge and District War Memorial Hospital and general practice buildings. As at 31 March 2021, the project is at a stage where the grant received is yet to be used (in part or in full) and therefore the grant has been deferred.

Note 24 Borrowings

The trust has no borrowings. Nil for 2019/20.

Note 25 Finance leases

Note 25.1 Kent Community Health NHS Foundation Trust as a lessor

The trust has no finance lease arrangements. Nil for 2019/20.

Note 25.2 Kent Community Health NHS Foundation Trust as a lessee

The trust has no finance lease obligations. Nil for 2019/20.

Note 26 Provisions for liabilities and charges analysis

	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2020	**290**	**91**	**1,296**	**1,677**
Arising during the year	111	71	-	**182**
Utilised during the year	(123)	(91)	(27)	**(241)**
Reversed unused	(43)	(9)	(492)	**(544)**
Unwinding of discount	**-**	**-**	11	**11**
At 31 March 2021	**235**	**62**	**788**	**1,085**
Expected timing of cash flows:				
– not later than one year	235	62	70	**367**
– later than one year and not later than five years	–	–	333	**333**
– later than five years	–	–	385	**385**
Total	**235**	**62**	**788**	**1,085**

The redundancy provision is a recognition of the expected redundancy costs associated with service changes. These are recognised following the development of detailed formal plans for service changes with uncertainties typically about which staff will be successful with re-deployment, etc. The legal provision includes on-going employment tribunals and the provision for Liabilities to Third Parties Scheme (LTPS) claims administered and informed by the NHS Resolution (see also Accounting Policy Notes 1.13 and 1.24).

The provisions classified as other, in the main include a provision (£717k) for dilapidations liabilities for the trust's commercially leased properties. The dilapidations provision represents the estimated re-instatement costs required when the trust is due to vacate the properties and has been advised by an external surveyor (BNP Paribas Real Estate).

Note 26.1 Clinical negligence liabilities

At 31 March 2021, £3,910k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Kent Community Health NHS Foundation Trust (31 March 2020: £3,182k).

Note 27 Contingent assets and liabilities

	31 March 2021 £000	31 March 2020 £000
Value of contingent liabilities		
NHS Resolution legal claims	(27)	(17)
Gross value of contingent liabilities	**(27)**	**(17)**
Amounts recoverable against liabilities	–	–
Net value of contingent liabilities	**(27)**	**(17)**
Net value of contingent assets	–	–

NHS Resolution legal claims – contingent liability relates to Liabilities to Third Party Scheme (LTPS) claims as administered and advised by NHS Resolution.

Note 28 Contractual capital commitments

	31 March 2021 £000	31 March 2020 £000
Property, plant and equipment	1,783	4,170
Intangible assets	–	–
Total	**1,783**	**4,170**

Note 29 Other financial commitments

The trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2021 £000	31 March 2020 £000
not later than 1 year	596	694
after 1 year and not later than 5 years	6,643	4,754
paid thereafter	1,232	2,640
Total	**8,471**	**8,088**

Note 30 Defined benefit pension schemes

The trust has no defined benefit schemes.

Note 31 Financial instruments

Note 31.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in carrying out its activities. Due to the continuing service provider relationship the trust has with NHS and local authority commissioners and the way those commissioners are financed, the trust is not exposed to the degree of financial risk faced by business entities. The trust as an NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the organisation in carrying out its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the organisation's standing financial instructions and policies agreed by the board of directors. Treasury activity is subject to review by the organisation's internal auditors.

Currency risk

The trust is a wholly UK based organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The organisation therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust has no borrowings and so is not exposed to any interest rate risk.

Credit risk

As the majority of the trust's revenue comes from contracts with other public sector bodies, the organisation has low exposure to credit risk. The maximum exposure as at 31 March 2021 is in receivables from customers, as disclosed in the trade and other receivables note. However, the trust exercises effective credit control processes including utilising external tracing and debt collection agencies, and court procedures to pursue overdue debt.

Liquidity risk

The trust's operating costs are incurred under contracts with commissioning organisations, which are financed from resources voted annually by parliament. The trust funds its capital expenditure through internally generated cash and if/where applicable, the Department of Health and Social Care central funding programmes. The organisation is not, therefore exposed to significant liquidity risks.

Note 31.2 Carrying values of financial assets

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2021				
Trade and other receivables excluding non financial assets	15,078	–	–	**15,078**
Cash and cash equivalents	42,859	–	–	**42,859**
Total at 31 March 2021	**57,937**	–	–	**57,937**

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2020				
Trade and other receivables excluding non financial assets	15,774	–	–	**15,774**
Cash and cash equivalents	44,666	–	–	**44,666**
Total at 31 March 2020	**60,440**	–	–	**60,440**

Note 31.3 Carrying values of financial liabilities

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2021			
Trade and other payables excluding non financial liabilities	28,011	–	**28,011**
Total at 31 March 2021	**28,011**	–	**28,011**

	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2020			
Trade and other payables excluding non financial liabilities	30,611	–	**30,611**
Total at 31 March 2020	**30,611**	–	**30,611**

Note 31.4 Maturity of financial liabilities

	31 March 2021 £000	31 March 2020 £000
In one year or less	28,011	30,611
In more than two years but not more than five years	–	–
In more than five years	–	–
Total	**28,011**	**30,611**

Note 31.5 Fair values of financial assets and liabilities

There is no material difference between the carrying value and fair value of the financial assets and liabilities shown above.

Note 32 Losses and special payments

	2020/21		2019/20	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	4	1	–	–
Bad debts and claims abandoned	175	42	178	48
Total losses	**179**	**43**	**178**	**48**
Special payments				
Ex-gratia payments	9	33	6	12
Total special payments	**9**	**33**	**6**	**12**
Total losses and special payments	**188**	**76**	**184**	**60**

Note 33 Related parties

All bodies within the scope of the Whole Government Accounts (WGA) are treated as related parties of an NHS foundation trust including the Department of Health and Social Care as the trust's parent organisation. A list of the main entities (those with transactions or balances of more than £1m) within the scope of the Whole Government Accounts (WGA) with which the trust has transacted with during the reporting period or has receivables or payables balances reported as at period end, are as follows:

NHS England
NHS Kent & Medway CCG
NHS East Sussex CCG
East Kent Hospitals University NHS Foundation Trust
Medway NHS Foundation Trust
Dartford and Gravesham NHS Trust
Maidstone And Tunbridge Wells NHS Trust
Health Education England
NHS Property Services
Kent County Council
Medway Council
East Sussex County Council
HM Revenue & Customs
NHS Pension Scheme

As at 31 March 2021, the trust has a receivable of £43k with Kent Community Health Charitable Fund whose corporate trustee is the Trust's Board of Directors. The accounts of the charity are available separately and are not included in these accounts as per note 1.3.

Note 34 Transfer by modified absorption accounting

On 1 March 2021, the ownership of College Road Clinic (located in Margate, Kent) was transferred to the trust from NHS Property Services. College Road Clinic was a former primary care trust asset and therefore the transfer of ownership (land and building) has been accounted for via modified absorption approach, in accordance with the DHSC GAM.

On transfer, the cost and accumulated depreciation balances from NHS Property Services' accounts have been preserved on recognition in the trust's accounts, with the gain on the transfer (£420k) being recognised directly in the income and expenditure reserve. In turn, the transferring revaluation reserve balance (£168k) attributable to the assets has been created via means of transfer from the income and expenditure reserve.

	£000
Transfer balances	
Gross book value	452
Accumulated depreciation	(32)
Gain on transfer (I&E Reserve)	**420**
Revaluation reserve	(168)
Net impact on I&E Reserve	**252**

Note 35 Events after the reporting date

On 1 April 2021, the ownership of Victoria Hospital (located in Deal, Kent) was transferred to the trust from NHS Property Services. Victoria Hospital was a former primary care trust asset and therefore the transfer of ownership (land and building) will be accounted for via modified absorption approach in April 2021 (financial year 2021/22).

The expected gain on transfer of Victoria Hospital to be recognised in the trust's income and expenditure reserve in April 2021 is £4.6m.

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